MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (124)

03246

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: WITHIN CORPORATE LIMITS OF Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 52 years

Hospital, Institution, or street address where death occurred:

Washington County Home

How long in hospital or institution? 2 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: WITHIN CORPORATE LIMITS OF Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Wash. County Home

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Lester K. Baker

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Viola Baker

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): May 6, 1892

8. AGE: Years	Months	Days	If less than one day
52	10	5	..... hrs. ..... min.

9. Birthplace: Hagerstown, Wash., Md. (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER — 12. Name: George Baker

13. Birthplace: Wash. Co., Md.

MOTHER — 14. Maiden name: Agnes Kuntz

15. Birthplace: Wash. Co., Md.

16. Informant: Mrs. Ira McKee

Address: 254 Frederick St.- Hagerstown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar. 13, 1945 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Hagerstown, Md.

18. Funeral director: Fred W. Kraiss

Address: Hagerstown, Md.

19. March 13 1945 (Date rec'd by registrar) Chas. H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 11, 1945 at 4:00 A. M. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 1 1945 to Mar 11 1945 and that I last saw h.. alive on Mar 7 1945

Immediate cause of death	DURATION
Cirrhosis Liver.	1 Yr.
Due to Chr. Interstitial Nephritis	1 Yr.
Due to Pulmonary Oedema.	1 Wk.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Ernest H. Rockland M. D. or other

Address: Hagerstown Md. Date signed: 3/12/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Dr Kneisley 148 W Washington St

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (5)

Dr. Kneisley

03247

CERTIFICATE OF DEATH

Reg. Dist. No. 302

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

M

1. PLACE OF DEATH:

County Washington

City or town Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 17 Days

Hospital, institution, or street address where death occurred:

Washington County Hospital

How long in hospital or institution? 17 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 41 South Locust St.

(If rural, give LOCATION)

2.(a) If veteran, name war None

3.(a) FULL NAME Mrs. Nellie Barr Bardenheur

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife William

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) December 5 1885

8. AGE: Years	Months	Days	If less than one day
59 59	3	7	..... hrs. ..... min.

9. Birthplace South Dakota (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own Home

FATHER 12. Name B. F. Barr

13. Birthplace Greencastle Pa.

MOTHER 14. Maiden name Prudence Price

15. Birthplace Greencastle Pa.

16. Informant Mrs. Lulu B. Minnich

Address Waynesboro Pa

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/15/45 (month) (day) (year)

Cemetery or crematory Green Hill Cemetery

Location Waynesboro Pa.

18. Funeral director Andrew K. Coffman

Address Hagerstown, Md.

19. March 13 1945 (Date rec'd by registrar) Chas. H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 12 1945, at 10 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 20, 1945, to March 12 1945

and that I last saw her alive on March 11, 1945

Immediate cause of death	DURATION
Intestinal obstruction	3 weeks
Due to Metastatic carcinoma	Indef.
Due to Other Conditions: Cystic carcinoma of ovaries	Indef
Other conditions Carcinoma of breast	

(Include pregnancy within 3 months of death)

Major findings of operations Same as above

Date of op. 3/2/45

Autopsy results 3/12/45 Same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE B. F. Kneisley M. D. or other

Address 148 W. Washington St., Date signed 3/13/45

389

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-d)

03248

CERTIFICATE OF DEATH

Reg. Dist. No. 30 2

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 yrs
Hospital, Institution, or street address where death occurred: 147 N. Jonathan
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 147 N. Jonathan
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Francis Black

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col	Married

6.(b) Name of husband or wife: Andrew Black
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
65	18	Aug	..... hrs. ..... min.

9. Birthplace: Winchester Va
(Town, county, and state)
10. Usual occupation: Housework
11. Industry or business

FATHER
12. Name: Daump Green Va
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Andrew Black
Address: 147 N. Jonathan St
17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 14, 45 (month) (day) (year)
Cemetery or crematory: Rose Hill Cemetery
Location: Hagerstown
18. Funeral director: William H. Downey
Address: 291 Frederick ST
19. March 16 19 45 Chas H. Bowers
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 11 1945 at 3.45 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 6 1944 to May 11 1945
and that I last saw her alive on May 1 1945

	DURATION
Immediate cause of death: Hemiplegia	9 mos
Due to: Hypertension	3 yrs
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Robert P. Conrad, M.D.
M. D. or other
Address: Hagerstown, Md Date signed: 3-13-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

CERTIFICATE OF DEATH

Dr. Yeager

03249

Reg. Diat. Nu. 302

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 months

Hospital, institution, or street address where death occurred: 52 E. Antietam St.

How long in hospital or institution? HOME

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Pennsylvania County: York

City or town: Hanover

(If outside city or town limits, write RURAL and give nearest town)

Street No. 205 E. Middle St.

(If rural, give LOCATION)

2.(a) If veteran, name war: No ✓

3.(a) FULL NAME: Mrs Clara May Bond

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: Edwin Cushion Bond

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): Jan. 31, 1864

8. AGE: Years	Months	Days	If less than one day
81	1	1	...hrs. ...min.

9. Birthplace: Shippensburg, York Co. Pa. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: —

FATHER — 12. Name: Thomas D. Smith

13. Birthplace: Dillsburg, Pa.

MOTHER — 14. Maiden name: Emma M. Whitesel

15. Birthplace: Shippensburg, Pa.

16. Informant: Ralph C. Bond

Address: 52 E. Antietam St Hagerstown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 4/45 (month) (day) (year)

Cemetery or crematory: New Oxford Cemetery

Location: New Oxford, Penn.

18. Funeral director: Andrew K Coffman

Address: Hagerstown Maryland.

19. March 6 1945 (Date rec'd by registrar) Chas H Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 1, 1945, at 2P. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Feb. 23, 1945, to March 1, 1945 and that I last saw h. on alive on Feb. 23, 1945

Immediate cause of death: Cerebral hemorrhage — DURATION: 10 Minutes

Due to: acute bronchitis — DURATION: Feb 23 45

Due to: ...

Other conditions: ...

(Include pregnancy within 3 months of death)

Major findings of operations: None — Date of op. —

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: X — Date of X

Where did injury occur? X (City or town) X (County) X (State)

Injured at home, farm, industry, public place (where?): ...

Means of injury: ... Injured at work?

23. SIGNATURE: W Howard Yeager M. D. or other

Address: Hagerstown, Md. Date signed: March 6, 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Dr. Beachley

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

03250

Reg. Dist. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 Hours

Hospital, institution, or street address where death occurred:

Washington County Hospital

How long in hospital or institution? 5 ours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 332 South St.

(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: William Russell Bowers

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: None

6.(c) If alive, give age: - years

7. Birth date of deceased (mo., day, yr.): December 13 1944

8. AGE: Years	Months	Days	If less than one day
-	3	3	hrs. min.

9. Birthplace: Hagerstown Wash. Co. Md.

(Town, county, and state)

10. Usual occupation: Infant

11. Industry or business: -

FATHER 12. Name: Russell M Bowers

13. Birthplace: Hagerstown Md.

MOTHER 14. Maiden name: Frances Trout

15. Birthplace: Frederick Md.

16. Informant: Russell M. Bowers

Address: Hagerstown Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/28/45 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Hagerstown Md.

18. Funeral director: Andrew K. Coffman

Address: Hagerstown Md.

19. March 28 1945 (Date rec'd by registrar) Chas. H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 26 1945 at 7 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 23 45 to March 26 45 and that I last saw h... alive on March 26 1945

Immediate cause of death	DURATION
Fracture of Skull	3 Days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of injury 3/23/45

Where did injury occur? Home (City or town) Hagerstown (County) Md. (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury: Fell from Kitchen Chair Injured at work? No.

23. SIGNATURE: J. K. Beachley M. D. or other

Address: Hagerstown Date signed ...

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-6)

03251

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:
County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 yrs
Hospital, institution, or street address where death occurred:
428 Summers ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 428 Summers ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME William E. Brent

3.(b) Social Security Number 219-05-2051

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col	Married

B.(b) Name of husband or wife Rosie Brent
B.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
50	Feb	24	hrs. 1895 min.

9. Birthplace Winchester Va.
(Town, county, and state)
10. Usual occupation Laborer
11. Industry or business

FATHER
12. Name unknown
13. Birthplace unknown

MOTHER
14. Maiden name unknown
15. Birthplace unknown

16. Informant Mrs Rosie Brent
Address 428 Summers ave

17. Burial Date thereof Mar 23. 45
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Rose Hill Cemetery County Hagerstown
Location Hagerstown

18. Funeral director William H. Downey
Address 391 Frederick St

19. March 22 1945 Hagerstown
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/24 1945 at 11 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 15 1945 to 3/24 1945
and that I last saw him alive on March 18 1945

Immediate cause of death Chronic Endocarditis
Due to Chronic Nephritis

DURATION	
?	
1	

Due to
Other conditions
(Include pregnancy within 3 months of death)

Major findings of operation 0
Date of op.
Autopsy results 0
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide 0 Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Victor D. Miller M. D. or other
Address DR. VICTOR D. MILLER 28 W. WASHINGTON ST. HAGERSTOWN, MD. Date signed 3/24/1945

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

nr. Poole

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 89-a

CERTIFICATE OF DEATH

03252

Reg. Dist. No. 302

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 Years
Hospital, institution, or street address where death occurred:
Washington County Home
How long in hospital or institution? 2 Years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No.: washington county Home
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3. (a) FULL NAME: Mrs. Daisy Fisher-Bristol

3. (b) Social Security Number: 213-16-1472

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Albert
6.(c) If alive, give age: - years

7. Birth date of deceased (mo., day, yr.): October 12 1877

8. AGE: Years	Months	Days	If less than one day
67	5	8	....hrs. ....min.

9. Birthplace: Mt. Jackson Page Co. Va.
(Town, county, and state)
10. Usual occupation: Housework
11. Industry or business: Own Home
FATHER 12. Name: James Alger
13. Birthplace: Mt. Jackson va.
MOTHER 14. Maiden name: Anna E. Strickler
15. Birthplace: Luray Va,
16. Informant: John H. Fisher
Address: Hagerstown Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/22/45 (month) (day) (year)
Cemetery or crematory: Rose Hill Cemetery
Location: Hagerstown Md.
18. Funeral director: Andrew K. Coffman
Address: Hagerstown Md.
19. March 22 19 45 (Date rec'd by registrar) Chas. H. Howard Registrar

MEDICAL CERTIFICATION A

20. DATE OF DEATH: March 20 1945 19.... at 10.30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 19 1945 to Mar 20 19 1945 and that I last saw h..er alive on Mar 14 19 45

Immediate cause of death	DURATION
Hemiplegia	1 1/2
Due to: Cerebral Hemorrhage	1 wk.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op.....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ....Date of.....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): .....
Means of injury: Injured at work?

23. SIGNATURE: Ernest F. Poole M.D. M. D. or other -
Address: Hagerstown Md Date signed: 3/21/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Dr Wells

03253

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

Reg. Dist. No. 302

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 12 yrs Unknown
Hospital, institution, or street address where death occurred:
Unknown
How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hagesrtwon
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Middleburg Pike
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3. (a) FULL NAME: Gilbert Brown

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: -
6.(c) If alive, give age: - years

7. Birth date of deceased (mo., day, yr.): Unknown

8. AGE: Years	Months	Days	If less than one day
Approx. 50			...hrs. ...min.

9. Birthplace: Hancock Wash. Co. Md.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: -

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Sheriffs Office of Wash. Co
Address: Hagerstown Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 4 1945 (month) (day) (year)
Cemetery or crematory: Bellvieu Cemetery
Location: Hagerstown Md.

18. Funeral director: Andrew K. Coffman
Address: Hagerstwon Md.

19. June 3 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: About March 14 1945 at ...M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ...19..., to ...19...
and that I last saw h... alive on ...19...

Immediate cause of death	DURATION
Senility	
Due to: Exposure to cold	48 hrs
Due to: and exhaustion	
Other conditions: Found dead in field	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.: ...
Autopsy results: no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: no Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE: I Robert Wells DEPUTY MEDICAL EXAM. WASH. CO., MD.
M. D. or other
Address: Hagerstown, Md. Date signed: 6/3/45

Dr. Kritzer

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-2)/4

CERTIFICATE OF DEATH

03254

Reg. Dist. No. 302

1. PLACE OF DEATH:
County: Was ington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 Years
Hospital, institution, or street address where death occurred:
910 Salem Ave
How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 910 Salem Ave
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: Mrs. Margaret Belle Brown

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Mitchell
6.(c) If alive, give age: 58 years

7. Birth date of deceased (mo., day, yr.): March 14 1889

8. AGE: Years	Months	Days	If less than one day
55	11	24	..... hrs. ..... min.

9. Birthplace: Charlestown Jefferson Co., W. Va.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Own Home

FATHER
12. Name: Joseph Mansfield
13. Birthplace: Charlestown W. Va.

MOTHER
14. Maiden name: Rachael Chapman
15. Birthplace: Charlestown W. Va.

16. Informant: Mitchell Brown
Address: Hagerstown Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/10/45 (month) (day) (year)
Cemetery or crematory: Rest Haven Cemetery
Location: Hagerstown Md.

18. Funeral director: Andrew K. Coffman
Address: Hagerstown Md.

19. Mar 10, 1945 (Date rec'd by registrar) Chas H Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 8 1945, 19..., at 6 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Feby 1- 1945, to Mch 8- 1945
and that I last saw h[illegible] alive on [illegible] Mch 7- 1945

Immediate cause of death	DURATION
Carcinoma of Lower bowel (Colon)	Mo.
Due to with metastasis to other pelvic organs -	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Hagerstown md Date signed 3-10-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. Beachley

03255 302

Reg. Dist. No.

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 Days

Hospital, institution, or street address where death occurred:

Washington Co. Hospital

How long in hospital or institution? 10 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 5 Moller Ave

(If rural, give LOCATION)

2.(a) If veteran, name war: No

3. (a) FULL NAME: Mrs. Emma Q Butterbaugh

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: John D.

6.(c) If alive, give age: 67 years

7. Birth date of deceased (mo., day, yr.): Sept. 23, 1879

8. AGE: Years	Months	Days	If less than one day
65	5	11	....hrs. ....min.

9. Birthplace: Mercersburg Franklin Co. Pa.
(Town, county, and state)

10. Usual occupation: House Wife

11. Industry or business: Own Home

FATHER
12. Name: Rankis Black
13. Birthplace: Mercersburg, Pa.

MOTHER
14. Maiden name: Harriett Rasp
15. Birthplace: Mercersburg, Pa.

16. Informant: John D. Butterbaugh
Address: Hagerstown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/6/45 (month) (day) (year)

Cemetery or crematory: Rest Haven Cemetery

Location: Hagerstown, Md.

18. Funeral director: Andrew K. Coffman

Address: Hagerstown, Md.

19. March 6 1945 (Date rec'd by registrar) Chas. H. Barnard Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 4 1945 at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from March 1 1945 to March 4 1945

and that I last saw h[illegible] alive on March 4 1945

Immediate cause of death: Acute Cardiac failure — DURATION: 6 hrs.

Due to:

Due to:

Other conditions: Chronic degenerative Syn, Chronic Nephritis Syn

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: J. L. Beachley M. D.

Address: Hagerstown, Md. Date signed: 3/6/45

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

03256

CERTIFICATE OF DEATH

Reg. Dist. No. 301

1. PLACE OF DEATH:
County Washington County
City or town Williamsport, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 50 yrs
Hospital, Institution, or street address where death occurred:
How long to hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Washington
City or town Williamsport, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. Salisbury St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Simon Brewer Byers

3.(b) Social Security Number 215097322

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Anna Byers
6.(c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) Nov. 15 1881

8. AGE: Years	Months	Days	If less than one day
63	2	21	hrs. min.

9. Birthplace Mercersburg Pa. (Town, county, and state)
10. Usual occupation Trimmer at Tannery
11. Industry or business Tannery Williamsport Md.
FATHER 12. Name Edward Byers
13. Birthplace Mercersburg Pa.
MOTHER 14. Maiden name Unknown
15. Birthplace Mercersburg Pa.
16. Informant Anna Byers (wife
Address Williamsport, Md. March
17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 10 1945 (month) (day) (year)
Cemetery or crematory Riverview Cemetery
Location Williamsport, Md.
18. Funeral director Edith V Leaf
Address #7 Church St. Williamsport, Md.
19. March 9 1945 (Date rec'd by registrar) Mrs E Le McElhy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 6 1945 at 5 15 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from last year 19 to Mar. 6 1945 and that I last saw him alive on Mar. 6 1945

Immediate cause of death	DURATION
Cardiac dilation.	1/48 day
Due to Arteris Sclerosis	1 Year
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE [signature] M. D. or other
Address Williamsport Date signed 3/9/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

13257

Reg. Dist. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 years

Hospital, institution, or street address where death occurred:

425 North Potomac

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 425 North Potomac

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Priscilla William Bridges Carmichael

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: John Carmichael

6.(c) If alive, give age: 69 years

7. Birth date of deceased (mo., day, yr.): Mar 29 — 1875

8. AGE: Years: about 69 | Months | Days | If less than one day: hrs. min.

9. Birthplace: Hancock, Maryland, Wash. Co. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER 12. Name: Robert Bridges

FATHER 13. Birthplace: Hancock, Maryland

MOTHER 14. Maiden name: Priscilla Breathed

MOTHER 15. Birthplace: Berkeley Springs, W.Va.

16. Informant: Miss Virginia Carmaichael

Address: Hagerstown, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-9-45 (month) (day) (year)

Cemetery or crematory: Rose Hill Mausoleum

Location: Hagerstown, Maryland

18. Funeral director: C. M. Suter & Sons

Address: Hagerstown, Maryland

19. March 8, 1945 (Date rec'd by registrar) C. Chas. H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 7, 1945, at 6:30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Feb. 7, 1932 to March 7, 1945 and that I last saw h. alive on March 6, 1945

Immediate cause of death	DURATION
Cardio-Renal Failure.	1 week
Due to Chronic Arterio Sclerosis	15 yrs
Due to Chronic Int. Nephritis	15 yrs
Atheromatous change	
Due to Uremia & Heart.	15 yrs.
Coronary Thrombosis	15 yrs
Other conditions Undulant Fever	15 yrs
Renal Calculus Lapp.	15 yrs
Bronchial Pneumonia	20 yrs
Emphysema & Lung	15 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W. Hound Tyeye M. D. or other

Address: Hagerstown, Md. Date signed: March 8, 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (734)

CERTIFICATE OF DEATH

03258

Reg. Diat. No. 302

1. PLACE OF DEATH:
County: Washington
City or town: Rural Cearfoss, Md.
(If ontside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Fairview Road- Hagerstown, R D 2
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Rural Cearfoss, Md.
(If ontside city or town limits, write RURAL and give nearest town)
Street No.: Fairview Road- Hagerstown, R D 2
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Harry V. Cearfoss

3.(b) Social Security Number: None

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married

8.(b) Name of husband or wife: Sallie J. Cearfoss
8.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feby. 10, 1867

8. AGE: Years: 78 | Months: 1 | Days: 10 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Cearfoss- Wash. Co., Md. (Town, county, and state)
10. Usual occupation: Farming
11. Industry or business

FATHER
12. Name: Simon Cearfoss
13. Birthplace: Washington County, Md.

MOTHER
14. Maiden name: Margaret McGuire
15. Birthplace: Wash. Co., Md.

16. Informant: Mrs. Edna Brinton
Address: Hagerstown, Md. R D 2

17. (Burial, cremation, or removal. Which?) Burial Date thereof (month) (day) (year) March 22 1945
Cemetery or crematory: Broadfording Cemetery
Location: Cearfoss Dist-

18. Funeral director: Fred W. Kraiss
Address: Hagerstown, Md.

19. (Date rec'd by registrar) March 22 1945 Chas H Beaver Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 20, 1945 10:00 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 15 -45 19..., to Mar 20 - 19 45
and that I last saw h— alive on Mar 16-45 19...

Immediate cause of death	DURATION
Cardiac Hemorrhage	one hour
Due to	
Chr. Myocarditis Arteriosclerosis	6 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause tu which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: E W Dietz M. D. or other
Address: Hagerstown Md Date signed 3-24-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03259

Reg. Diat. No. 302

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 yrs
Hospital, institution, or street address where death occurred:
111 Blooms ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 111 Blooms ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Howard Colmes

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 27 | Months | Days | If less than one day ... hrs. ... min.

9. Birthplace Hagerstown (Town, county, and state)
10. Usual occupation Laborer
11. Industry or business
FATHER 12. Name William Colmes
FATHER 13. Birthplace Lindonwarp Pa
MOTHER 14. Maiden name Julia Colmes
MOTHER 15. Birthplace Yorkhill Pa
16. Informant Mrs Julia Colmes
Address 111 Blooms ave
17. Burial (Burial, cremation, or removal. Which?) Date thereof March 13 45 (month) (day) (year)
Cemetery or crematory Rose Hill Cemetery
Location Hagerstown
18. Funeral director Gillian H Downs
Address 291 Frederick St
19. March 13 19 45 (Date rec'd by registrar) Chas H Bookert Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 10 19 45, at 4 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 17 19 45, to Mar 10 19 45
and that I last saw h. alive on Mar 10 19 45

	DURATION
Immediate cause of death Pulmonary Tuberculosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE P. I. Grather M. D. or other
Address Hagerstown Md Date signed 3/13/45

Dr. Prather

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302 — 03260

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 Days

Hospital, institution, or street address where death occurred: Washington County Hospital

How long in hospital or institution? 4 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washongton

City or town: Hagerstwon

(If outside city or town limits, write RURAL and give nearest town)

Street No. 70 East Antietam St.

(If rural, give LOCATION)

2.(a) If veteran, name war: World War # 1

3.(a) FULL NAME: John Keeffer Crilley

3.(b) Social Security Number: 214-10-5389

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Ottie

6.(c) If alive, give age: 44 years

7. Birth date of deceased (mo., day, yr.): October 9 1893

8. AGE: Years	Months	Days	If less than one day
51	4	25	..... hrs. ..... min.

9. Birthplace: Hagerstown Wash. Co. Md. (Town, county, and state)

10. Usual occupation: Dispatcher

11. Industry or business: Blue Ridge Lines

FATHER — 12. Name: Samuel Crilley

FATHER — 13. Birthplace: Williamsport Md.

MOTHER — 14. Maiden name: Catherine Holbert

MOTHER — 15. Birthplace: Clearspring Md.

16. Informant: Mrs Ottie Crilley

Address: Hagerstown Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/8/45 (month) (day) (year)

Cemetery or crematory: Dunkard cemetery

Location: Broadfording Md.

18. Funeral director: Andrew K. Coffman

Address: Hagerstown Md.

19. March 7 19 45 (Date rec'd by registrar) Chas H Boards Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 6 1945 19..... at 3 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 16 19 45 to Mar. 6 19 45 and that I last saw h... alive on Mar 6 19 45

Immediate cause of death	DURATION
Peripheral Vascular collapse.	3 hours
Rheumatic Malaria.	10 days
Due to Pareus.	7
Due to Acute encephalitis by bluitis.	1
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: Moderate congestion & viscera.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: W. F. Prather M. D.

Address: Hagerstown, Md. Date signed: 3/7/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

03261

Reg. Dist. No. 302

Dr. Norment

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown (IN INCORPORATED LIMITS)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 60 years.
Hospital, Institution, or street address where death occurred: 347 S. Cannon Ave.
How long in hospital or Institution? at Home.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hagerstown (IN INCORPORATED LIMITS)
(If outside city or town limits, write RURAL and give nearest town)
Street No. 347 S. Cannon Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: John Snively Criswell

3.(b) Social Security Number: 214-09-0824

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Carrie Baker Criswell
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May - 9 - 1874

8. AGE: Years	Months	Days	If less than one day
70	10	19	..... hrs. ..... min.

9. Birthplace: Keedysville Wash. Co. Md. (Town, county, and state)
10. Usual occupation: Receiving Clerk
11. Industry or business: Hotel Alexander
FATHER 12. Name: Joseph Criswell
FATHER 13. Birthplace: Keedysville Wash. Co. Md.
MOTHER 14. Maiden name: Elizabeth Snively
MOTHER 15. Birthplace: Keedysville Wash. Co. Md.
16. Informant: Mrs. Carrie B. Criswell
Address: 347 S. Cannon Ave. Hagerstown Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 31 1945 (month) (day) (year)
Cemetery or crematory: Bemerton Cemetery
Location: Bemerton Md.
18. Funeral director: Wm. J. Bast & Sons
Address: Boonsboro Md.
19. Mar. 30. 1945 (Date rec'd by registrar) Chas H Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 28. 1945, at 7 00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 26 1945, to March 28. 1945
and that I last saw him alive on March 28. 1945

Immediate cause of death	DURATION
Coronary disease	3 yrs.
Due to: with Coronary occlusion	
Due to: Sclerotic arteries	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations: None
Date of op. .....
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: None
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: (B) Norment MD
Address: Hagerstown, Md
M. D. or other
Date signed: 3/29/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

03262

CERTIFICATE OF DEATH

Reg. Dist. No. 305

1. PLACE OF DEATH:
County: Washington
City or town: Fairplay Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred: Boonsboro Md. R. 1
How long in hospital or institution? at Home

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Fairplay Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No. Boonsboro Md. R. 1
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: Mary Ann Daugherty

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Geo. Alexander Daugherty
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): January - 24 - 1865

8. AGE: Years 80 | Months 2 | Days 15 | If less than one day ..... hrs. ..... min.

9. Birthplace: Tilghmanton Wash. Co. Md.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Own Home.
FATHER 12. Name: Jacob Bloom
13. Birthplace: Wash. Co. Md.
MOTHER 14. Maiden name: Ellen Fitch
15. Birthplace: Wash. Co. Md.
16. Informant: Mrs. Omer Hennessy
Address: Boonsboro Md. R. 1
17. Burial (Burial, cremation, or removal. Which?) Date thereof April 1. 1945 (month) (day) (year)
Cemetery or crematory: Masons Cemetery
Location: Near Tilghmanton Md.
18. Funeral director: Ury F. Bast and Sons
Address: Boonsboro Md.
19. April 1. 1945 (Date rec'd by registrar) John H. Bast Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 29 1945 at 1 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1/1/45 19.. to 3/29/45 19.. and that I last saw h.. alive on 3/29/45 19..

Immediate cause of death	DURATION
Hypostatic Pneumonia	3 Days
Due to: Hypertensive Cardio-Vascular Renal Disease	3 yrs.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Ralph F. Young M. D. or other
Address: Williamsport Md. Date signed 3/30/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (89-a)

CERTIFICATE OF DEATH

03263

Reg. Diat. No. 302

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Washington

City or town Hagerstown, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 years

Hospital, institution, or street address where death occurred:

834 Mulberry Avenue

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 834 Mulberry Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Sarah M. Dawson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife Joseph T. Dawson

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 30, 1855

8. AGE: Years	Months	Days	If less than one day
89	8	17	..... hrs. ..... min.

9. Birthplace Page County, Virginia (Town, county, and state)

10. Usual occupation Housework

11. Industry or business

FATHER 12. Name Not Known

13. Birthplace

MOTHER 14. Maiden name Not Known

15. Birthplace

16. Informant Palmer Dawson

Address Hagerstown, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-16-45 (month) (day) (year)

Cemetery or crematory Rest Haven Cemetery

Location Hagerstown, Maryland

18. Funeral director C. M. Suter & Sons

Address Hagerstown, Maryland

19. March 15 1945 Chas. H. Bowers (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 13, 1945 at 8:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 13, 1945 to Mar. 13, 1945 and that I last saw h.. alive on March 13, 1945

Immediate cause of death	DURATION
Cerebral apoplexy	5 hours
Due to	
Due to	
Other conditions Arteriosclerosis	2

(Include pregnancy within 3 months of death)

Major findings of operations No operation Date of op.

Autopsy results No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

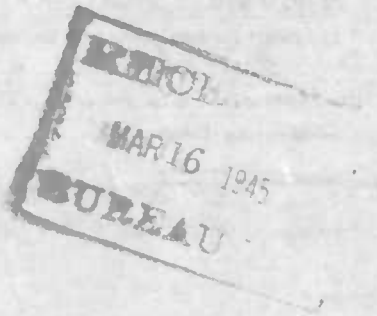
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE La Bree M. D. or other

Address Hagerstown Md. Date signed 3/14/45


MAR 16 1945
BUREAU

Dr. Brewer

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-a

CERTIFICATE OF DEATH

Reg. Dist. No. 03264 303

1. PLACE OF DEATH:
County: Washington
City or town: ~~Hagerstown~~ Clearspring
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 76 Years
Hospital, institution, or street address where death occurred:
Cumberland St.
How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Clearspring
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Cumberland st
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3. (a) FULL NAME: William Bruce Deeds

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Lydia
6.(c) If alive, give age: 68 years
7. Birth date of deceased (mo., day, yr.): March 10 1869

8. AGE: Years	Months	Days	If less than one day
76	-	4	....hrs. ....min.

9. Birthplace: Clearspring Wash. Co. Md.
(Town, county, and state)
10. Usual occupation: Rural Mail n Carrier
11. Industry or business: Retired

FATHER
12. Name: John S. Deeds
13. Birthplace: Clearspring Md.

MOTHER
14. Maiden name: Elizabeth Strock
15. Birthplace: Clearspring Md.

16. Informant: Mrs. Frank L. Shaffer
Address: Hagerstown Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/17/45 (month) (day) (year)
Cemetery or crematory: Luthern Cemetery
Location: Clearspring Md.

18. Funeral director: Andrew K. Coffman
Address: Hagerstown Md.

19. Mar 16. 1945 (Date rec'd by registrar) Joseph W. Murray Registrar

MEDICAL CERTIFICATION P

20. DATE OF DEATH: March 14 1945 19.... at 7.30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 7. 1945 to Mar 14 1945
and that I last saw him alive on Mar 14. 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	7 days.
Due to Arterio Sclerosis	3 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ....Date of op. ....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to exteroat causes, fill in the following:
Accident, suicide, or homicide: .... Date of ....
Where did injury occur? .... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ....
Means of injury: .... Injured at work?

23. SIGNATURE: David R. Brewer M.D.
M. D. or other
Address: Clear Spring Md. Date signed: 3/15/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Dr. Kneisley

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

03265

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:
County Washington (OUTSIDE CITY LIMITS)
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 Months
Hospital, institution, or street address where death occurred:
26 High St
How long in hospital or institution? --

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland (OUTSIDE CITY LIMITS) County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 26 High St.
(If rural, give LOCATION)
--
2.(a) If veteran, name war

3.(a) FULL NAME Charles Ernest Derr

3.(b) Social Security Number --

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife --
6.(c) If alive, give age --

7. Birth date of deceased (mo., day, yr.) November 14 1944

8. AGE: Years	Months	Days	If less than one day
	3	7	..hrs. ..min.

9. Birthplace Hagerstown wash. Co. Md.
(Town, county, and state)
10. Usual occupation Infant
11. Industry or business --

FATHER
12. Name William Derr
13. Birthplace Hagerstown Md.

MOTHER
14. Maiden name Emma Cauffman
15. Birthplace HagerstownMd

16. Informant Mrs. Emma C. Derr
Address Hagerstown Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 23 45 (month) (day) (year)
Cemetery or crematory Rose HiLL
Location Hagerstown Md.

18. Funeral director Andrew K. Coffman
Address Hagerstown Md.

19. March 22 18 45 (Date rec'd by registrar) Chas H Boovers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 21 1945 19.., at 5 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 21, 1945 19.., to March 21, 19.45 and that I last saw him alive on Jan. 15, 1945. 19..

Immediate cause of death	DURATION
Bronchopneumonia	3 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Bob Kneisley M.D. M. D. or other
Address 148 W. Washington St. Date signed 3/22/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (70-2)

CERTIFICATE OF DEATH

Dr. Wells

03266

Reg. Dist. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 Day

Hospital, institution, or street address where death occurred:

Washington County Hospital

How long in hospital or institution? 1 Day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Indiana Ave

(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: Mrs. Bertha Snyder Durben

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Frank L.

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): March 15 1877

8. AGE: Years	Months	Days	If less than one day
68	0	16	... hrs. ... min.

9. Birthplace: Downsville Wash. Co. Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own Home

FATHER
12. Name: George Snyder
13. Birthplace: Downsville Md.

MOTHER
14. Maiden name: Mary Smith
15. Birthplace: Downsville Md.

16. Informant: Elder G. Snyder

Address: Hagerstown Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 4/3/45 (month) (day) (year)

Cemetery or crematory: Rest Haven Cemetery

Location: Hagerstown Md.

18. Funeral director: Andrew K. Coffman

Address: Hagerstown Md.

19. April 3 1945 (Date rec'd by registrar) Chas. H. Bowers, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 31 1945 19... at 3.20 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...

and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Intra abdominal hemorrhage	
Due to dislocation rt hip joint	
Due to Shock	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: No ... Date of op. ...

Autopsy results: No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of injury: 3/30/45

Where did injury occur? Hagerstown (City or town) Wash. (County) Md. (State)

Injured at home, farm, industry, public place (where?): Salem Ave.

Means of injury: Struck by auto Injured at work? No

23. SIGNATURE: Robert Wells DEPUTY MEDICAL EXAM. WASH. CO., MD. M. D. or other

Address: Hagerstown, Md. Date signed: 4/2/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (740)

03267

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 67 years
Hospital, institution, or street address where death occurred: 542 N Locust St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother) Washington
State: Maryland County:
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 542 North Locust
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3.(a) FULL NAME: J. Harry Earhart

3.(b) Social Security Number: No

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): November 11, 1877.

8. AGE: Years	Months	Days	If less than one day
67	4	18	hrs. min.

9. Birthplace: Hagerstown, Md.
(Town, county, and state)

10. Usual occupation: Retired office accountant

11. Industry or business

FATHER
12. Name: John H. Earhart
13. Birthplace: Hagerstown

MOTHER
14. Maiden name: Mary C. Mc Carter
15. Birthplace: Hagerstown

18. Informant: Mrs Cora E. Socks (Sister)
Address: 68 Winter St, Hagerstown

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: April 2, 1945
(month) (day) (year)

Cemetery or crematory: Rose Hill
Location: Hagerstown

18. Funeral director: Fred W. Kraiss
Address: Hagerstown

19. April 2 1945 Chas H Boarer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION P.M.

20. DATE OF DEATH: March 29 19 45 at 9:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 24-45 19 Mar 29-45 19
and that I last saw him alive on Mar 24-45 19

Immediate cause of death: Coronary Thrum — DURATION: 6 mo

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W Earhart M. D. or other
Address: Hagerstown Md Date signed 4/4/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

03268

Reg. Dist. No. 305

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County: Washington

City or town: Boonsboro

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred: St. Paul St.

How long in hospital or institution? at Home

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Boonsboro

(If outside city or town limits, write RURAL and give nearest town)

Street No.: St. Paul St.

(If rural, give LOCATION)

2.(a) If veteran, name war: none

3. (a) FULL NAME: Harry Ford

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: Single

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): September - 23 - 1872

8. AGE: Years	Months	Days	If less than one day
72	6	2	..... hrs. ..... min.

9. Birthplace: Boonsboro Wash. Co. Md. (Town, county, and state)

10. Usual occupation: Retired Painter

11. Industry or business

FATHER

12. Name: Joshua Ford

13. Birthplace: Boonsboro Wash. Co. md.

MOTHER

14. Maiden name: Mary Brish

15. Birthplace: Boonsboro Wash. Co. md.

16. Informant: Miss Mary Ford

Address: Boonsboro md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 28, 1945 (month) (day) (year)

Cemetery or crematory: Boonsboro Cemetary

Location: Boonsboro md.

18. Funeral director: W. J. Bast & Sons

Address: Boonsboro md.

19. Mar. 28, 1945 (Date rec'd by registrar) John N. Bast Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 25 1945 at 5 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1 1945 to March 25 1945

and that I last saw him alive on March 24 1945

Immediate cause of death	DURATION
Chronic Myocarditis	8 yr.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: G. W. Leikey M.D

M. D. or other

Address: Boonsboro Date signed: 3/27/45

Dr. Ditto
03269

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore B-C

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:
County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 Year
Hospital, institution, or street address where death occurred:
57 Madison Ave
How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 57 Madison Ave
(If rural, give LOCATION)
2.(a) If veteran, name war None

3.(a) FULL NAME Mrs. Frances Elizabeth Garula

3.(b) Social Security Number 220-16-1433

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Michael
6.(c) If alive, give age 32 years

7. Birth date of deceased (mo., day, yr.) March 16 1917

8. AGE: Years	Months	Days	If less than one day
27	11	19	..... hrs. ..... min.

9. Birthplace Shady Grove Franklin Co. Pa. (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business Own Home
FATHER 12. Name Lawson Keller
13. Birthplace Shady Grove Pa.
MOTHER 14. Maiden name Pearl Schrader
15. Birthplace Shady Grove Pa.
16. Informant Michael Garula
Address Hagerstown Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/8/45 (month) (day) (year)
Cemetery or crematory Rose Hill Cemetery
Location Hagerstown Md.
18. Funeral director Andrew K. Coffman
Address Hagerstown Md.
19. March 6 1945 (Date rec'd by registrar) Chas. H. Bowers Registrar

MEDICAL CERTIFICATION A

20. DATE OF DEATH March 5 1945 19..... at 4.30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 1- 45 19..... to Mar 5 1945
and that I last saw h.... alive on Mar 3-45 19.....

Immediate cause of death	DURATION
Pulmonary T. B.	2 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE D. W. Duttera M. D. or other
Address Hagerstown Md. Date signed 3/6/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Dr. Wade. (M)

03270

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18a)

CERTIFICATE OF DEATH

Reg. Dist. No. 305

1. PLACE OF DEATH:

County: Washington

City or town: Appletown - Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred: Boonsboro Md. R. 2

How long in hospital or institution? at House

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Appletown - Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No. Boonsboro Md. R. 2
(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: Mary Ellen Green

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Jacob M. Green

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): January - 28 - 1858

8. AGE:

Years	Months	Days	If less than one day
87	1	5	..... hrs. ..... min.

9. Birthplace: Near Keedysville Wash. Co. Md.
(Town, county, and state)

10. Usual occupation: Housekeeper

11. Industry or business: Own Home.

FATHER
12. Name: Philip Lapole
13. Birthplace: Wash. Co. Md.

MOTHER
14. Maiden name: Mary Stone
15. Birthplace: Wash. Co. Md.

16. Informant: Mrs. Charles Green
Address: Boonsboro Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 6 1945 (month) (day) (year)

Cemetery or crematory: Boonsboro Cemetery

Location: Boonsboro Md.

16. Funeral director: Wm. D. Bast & Sons

Address: Boonsboro Md.

19 March 5 1945 John H. Bast
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 3" 1945, at 4:30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 26" 1945, to March 3" 1945

and that I last saw h... alive on March 2" 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	5 days.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: J. Hubert Wade M. D.
M. D. or other

Address: Boonsboro, Md. Date signed 3/3/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Dr. Porterfield

03271

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

CERTIFICATE OF DEATH

Reg. Diat. No. 302

1. PLACE OF DEATH:

County Washington

City or town Hagerstown (WITHIN CORPORATE LIMITS OF)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 weeks

Hospital, institution, or street address where death occurred:

Washington County Hospital

How long in hospital or institution? 5 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. Cavetown Pike

(If rural, give LOCATION)

2.(a) If veteran, name war None

3. (a) FULL NAME Mrs. Virginia Haycock Griffith

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Married

6.(b) Name of husband or wife Earl E.

6.(c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) January 8 1893

8. AGE: Years	Months	Days	If less than one day
52	2	15	..... hrs. ..... min.

9. Birthplace Wardensville Hardy Co W. Va. (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own Home

FATHER

12. Name James Haycock

13. Birthplace Wardensville W. Va.

MOTHER

14. Maiden name Hannah Ellis

15. Birthplace Massachusetts

16. Informant Earl E. Griffith

Address Hagerstown Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/25/45 (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Hagerstwon Md.

18. Funeral director Andrew K. Coffman

Address Hagerstown Md.

19. Mar 24, 1945 (Date rec'd by registrar) Chas H Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23 1945 19..... at 2 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 13 19 45, to Mar 23 19 45

and that I last saw h.. er alive on Mar 22 19 45

Immediate cause of death	DURATION
Diagnosis to await autopsy results.	
Due to Bronchopneumonia.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results Bronchopneumonia.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE H. E. Porterfield M.D. M. D. or other

Address 136 W Washington Date signed 3/24/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (85a)

CERTIFICATE OF DEATH

03272

Reg. Diat. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 years.

Hospital, Institution, or street address where death occurred: Rear - 145 Ray St.

How long in hospital or institution? at Home

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Rear of 145 Ray St.

(If rural, give LOCATION)

2.(a) If veteran, name war: - None -

3. (a) FULL NAME: William Henry Gross

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mrs. Mary Gross

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): August. 17 - 1871

8. AGE:

Years	Months	Days	If less than one day
73	7	7	..... hrs. ..... min.

8. Birthplace: Near Boonsboro Wash. Co. Md.

(Town, county, and state)

10. Usual occupation: None

11. Industry or business: —

FATHER

12. Name: Nathaniel Gross

13. Birthplace: Near Boonsboro Wash. Co. Md.

MOTHER

14. Maiden name: Manzella Reeder

15. Birthplace: Rohrersville Wash. Co. Md.

16. Informant: Mrs. Ada V. Knodle

Address: 145 Ray St. Hagerstown Md.

17. Burial. (Burial, cremation, or removal, Which?) Date thereof: March. 27. 1945 (month) (day) (year)

Cemetery or crematory: Boonsboro Cemetary

Location: Boonsboro Md.

18. Funeral director: (Mrs.) Bart & Sons

Address: Boonsboro Md.

19. Mar 25. 1945 (Date rec'd by registrar) Chas H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 23 '45 19..... at 5 AM M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
.....	.....
Due to: acute cerebral hemorrhage	.....
Due to: vassular Hypertension	5yrs
Other conditions	.....

(Include pregnancy within 3 months of death)

Major findings of operations: .....

Date of op. .....

Autopsy results: No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: No Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: L Roberts Wells DEPUTY MEDICAL EXAM. WASH. CO., MD.

Address: Hagerstown, Md. M. D. or ..... Date signed: 3/24/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 51-2

CERTIFICATE OF DEATH

03273

Reg. Dist. No. 302

1. PLACE OF DEATH:
County Washington
City or town Hagerstown, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
Washington County Hospital
How long in hospital or institution? 25 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Washington
City or town Hagerstown,
(If outside city or town limits, write RURAL and give nearest town)
Street No. 498 Potomac Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Albert Heard

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife Mollie Heard
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) August 28, 1860

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
84	6	4		

9. Birthplace Hagerstown, Wash.Co. Md.
(Town, county, and state)
10. Usual occupation Water Supt.
11. Industry or business Wash.Co. Water Company
FATHER 12. Name Franklin A. Heard
13. Birthplace Hagerstown, Maryland
MOTHER 14. Maiden name Mary Ann Mobley
15. Birthplace Hagerstown, Maryland
16. Informant Miss Helen Heard
Address Hagerstown, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-6-45 (month) (day) (year)
Cemetery or crematory Rose Hill Cemetery
Location Hagerstown, Maryland
18. Funeral director C. M. Suter & Sons
Address Hagerstown, Maryland
19. March 6 1945 (Date rec'd by registrar) Chas. H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 4 1945, at 6 P. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Feb 1 1939, to Mar 4 1945
and that I last saw h.. alive on Mar 4 1945

Immediate cause of death	DURATION
Carcinomma Prostate	2/1/39
metastasis pelvis + bladder	
Due to Uraemia	2/20/45
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE H. H. Porterfield M.D.
M. D. or other
Address 136 W Wash St Date signed 3/6/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

03274

CERTIFICATE OF DEATH

Reg. Dist. No. 305

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Washington

City or town: Boonsboro

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Died while at Work

Hospital, Institution, or street address where death occurred: Boonsboro Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Sapland I Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No. Sapland Md.

(If rural, give LOCATION)

2.(a) If veteran, name war: None

3. (a) FULL NAME: Samuel Harvey Hines

3. (b) Social Security Number: 579-01-3310

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

B.(b) Name of husband or wife: Nina M. Hines

B.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 11. 1892

8. AGE: Years	Months	Days	If less than one day
52	6	1	hrs. min.

9. Birthplace: Boonsboro Washington Co. Md.

(Town, county and state)

10. Usual occupation: Mechanic

11. Industry or business: Garage.

FATHER

12. Name: John Hines

13. Birthplace: Wash. Co. Md.

MOTHER

14. Maiden name: Catherine Hines

15. Birthplace: Wash. Co. Md.

16. Informant: Mrs. Nina M. Hines

Address: Sapland Md.

17. Burial. (Burial, cremation, or removal. Which?) Date thereof March. 14. 1945 (month) (day) (year)

Cemetery or crematory: Locust Grove Cemtary

Location: Locust Grove Md.

18. Funeral director: Wm J. Bast & Sons

Address: Boonsboro Md.

19. March. 14 19 45 (Date rec'd by registrar) John H. Bast Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 12 19 45 at 8:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 12 19 45, to March 12 19 45 and that I last saw him alive on March 12 19 45

Immediate cause of death: Coronary Thrombosis.

DURATION

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

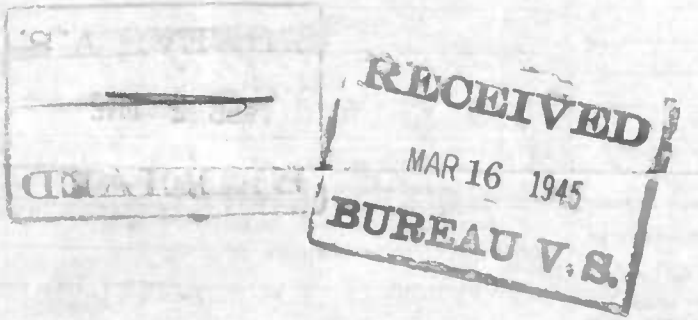
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: G. H. LeVan M.D. M. D. or other

Address: Boonsboro, Md. Date signed 3/13/45


RECEIVED
MAR 16 1945
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03275

Reg. Dist. No. 302

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 54 years
Hospital, Institution, or street address where death occurred:
43 E Washington
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 43 E Washington
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Anna M Hoover

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	Widowed

6.(b) Name of husband or wife David C Hoover
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug 29 - 1857

8. AGE: Years	Months	Days	If less than one day
87	6	19	..... hrs. ..... min.

9. Birthplace Leitersburg Washington Md
(Town, county, and state)
10. Usual occupation None
11. Industry or business

FATHER
12. Name Joseph Wishard
13. Birthplace Near Waynesboro Pa

MOTHER
14. Maiden name Rebecca Wolbrunner
15. Birthplace Leitersburg Md

16. Informant Mrs. S. M. Zeink
Address Hagerstown Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar 20 - 1945 (month) (day) (year)
Cemetery or crematory Rose Hill
Location Hagerstown
18. Funeral director Scott F Minnick & Son
Address Hagerstown Md
19. March 20 1945 (Date rec'd by registrar) Chas H Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 16 1945 at 2.50 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3/15/45 19.. to March 18, 1945
and that I last saw h.. er alive on March 17, 1945 19..

Immediate cause of death	DURATION
Hypostatic pulmonary congestion	24 hrs.
Due to Myocarditis	Indef.
Due to General arteriosclerosis	Indef.
Due to	
Other conditions Hypotrophic arthritis	Indef.
Fracture of right humerous (accident)	12days

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of 3/15/45
Where did injury occur? Hagerstown (City or town) Washington (County) Md. (State)
Injured at home, farm, industry, public place (where?) Home
Means of injury fell out of bed Injured at work?

23. SIGNATURE B B Schneider M.D. M. D. or other
Address 148 W. Washington St. Date signed 3/19/45

Dr Schneider

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

CERTIFICATE OF DEATH

63276

Reg. Dist. No. 307

1. PLACE OF DEATH:

County: Washington

City or town: Locust Grove - Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 17 years

Hospital, institution, or street address where death occurred:

Rohersville Md. R. 1

How long in hospital or institution? at Home

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Locust Grove - (Rural)

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Rohersville Md. R. 1

(If rural, give LOCATION)

2.(a) If veteran, name war: None.

3. (a) FULL NAME: Harvey William Houser

3. (b) Social Security Number: 220-10-3926.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mrs. Mary Houser.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): September 19, 1882

8. AGE: Years	Months	Days	If less than one day
62	4	13	..... hrs. ..... min.

9. Birthplace: Samples Manor Wash. Co. Md. (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Victor Products Co.

FATHER
12. Name: William J. Houser
13. Birthplace: Samples Manor Wash. Co. Md.

MOTHER
14. Maiden name: Susan E. Gardner
15. Birthplace: Near Sharpsburg Wash. Co. Md.

16. Informant: Mrs. Mary Houser
Address: Rohersville Md. R. 1

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 5, 1945 (month) (day) (year)

Cemetery or crematory: Samples Manor Cemetary

Location: Samples Manor Md.

18. Funeral director: Wm. J. Bart & Son

Address: Boonsboro Md.

19. Mar. 4 1945 (Date rec'd by registrar) Mrs. Katherine Engelhart Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 2" 1945 at 3 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 7" 1943, to Mar. 2" 1945 and that I last saw h... alive on February 20" 1945

Immediate cause of death	DURATION
Chronic Myocarditis	1yr. 10 mo. 25 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: J. Hubert Mader M. D.
M. D. or other

Address: Boonsboro Md. Date signed: 3/3/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Dr. Wade.

Dr. Layman

03277

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 Years

Hospital, institution, or street address where death occurred:

533 Brown Ave

How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 533 Brown Ave

(If rural, give LOCATION)

2.(a) If veteran, name war: None

3. (a) FULL NAME: Mrs. Ruby Black Hutton

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Abraham

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): April 23 1875

8. AGE: Years	Months	Days	If less than one day
69	10	13	..... hrs. ..... min.

9. Birthplace: Sugar Grove Smith Co. Va. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own Home

FATHER — 12. Name: Mitchell Scott

FATHER — 13. Birthplace: Sugar Grove Va.

MOTHER — 14. Maiden name: Amanda Edmondson

MOTHER — 15. Birthplace: Meadow View Va.

16. Informant: Mrs. Eugene Scott

Address: Rockville Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 3/7/45 (month) (day) (year)

Cemetery or crematory: Hildebrand Cemetery

Location: near Waynesboro Va.

18. Funeral director: Andrew K. Coffman

Address: Hagerstown Md.

19. March 7 1945 (Date rec'd by registrar) Chas H Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 6 1945 at 5.10 A M

21. I CERTIFY, that death occurred on the date above stated: that I attended deceased from Feb. 6 1945 to Mar 6 1945

and that I last saw her alive on Mar 5 1945

Immediate cause of death	DURATION
Cerebral edema	
Due to arteriosclerosis and	
Due to hypertension years	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Hector Layman M.D. M. D. or C.

Address: Hagerstown, Md. Date signed: 3/7-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Evidence for change of age is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

03278

FILE No. G 94 MAY 15 1945

CERTIFICATE OF DEATH

Reg. Diat. No. 302

1. PLACE OF DEATH:

County Washington

City or town Hagerstown, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month

Hospital, institution, or street address where death occurred:
1817 Virginia Avenue

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1817 Virginia Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Elizabeth Ireland

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) December 10, 1860

8. AGE:	Years	Months	Days	If less than one day
	84 ~~85~~	2	21~~18~~	..... hrs. ..... min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual occupation Housework

11. Industry or business

FATHER 12. Name John H. Ireland

13. Birthplace Baltimore, Maryland

MOTHER 14. Maiden name Elizabeth Ann Pickney

15. Birthplace Baltimore, Maryland

16. Informant Rev. Hartzell

Address Hagerstown, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3 - 5 - 1945 (month) (day) (year)

Cemetery or crematory Loudon Park Cemetery

Location Baltimore, Maryland

18. Funeral director C. M. Suter & Sons

Address Hagerstown, Maryland

19. March 2 1945 (Date rec'd by registrar) Chas. H. Beavers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 1 - 45 19 ..... at 10 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Feb 26 45 19 to Mar 1 - 45 19 and that I last saw alive on Feb 26 45 19

	DURATION
Immediate cause of death	
Chr. Myocarditis	6 yrs
Due to	
Due to Arteriosclerosis	10 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE J. W. Oates M. D. or other

Address 215 W. Wash. St. Date signed 3/1/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-c)

CERTIFICATE OF DEATH

03279

Reg. Dist. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 24 hrs.

Hospital, institution, or street address where death occurred: Wash. Co. Mt. Hosp.

How long in hospital or institution? 24 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Beaverdam — Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Boonsboro Md. R. 1

(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: Hubert C. Jackson

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single.

6.(b) Name of husband or wife: Single.

9.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 26 1905

8. AGE: Years	Months	Days	If less than one day
39	10	22	..... hrs. ..... min.

9. Birthplace: Mt. Lena Wash. Co. Md.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: On Farm

FATHER — 12. Name: Charles Jackson

FATHER — 13. Birthplace: Mapleville Wash. Co. Md.

MOTHER — 14. Maiden name: Cora Griffith

MOTHER — 15. Birthplace: Near Boonsboro Wash. Co. Md.

16. Informant: Mrs. Cora Lawson

Address: Myersville Md. R. 1

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 21 1945 (month) (day) (year)

Cemetery or crematory: Boonsboro Cemetary

Location: Boonsboro Md.

19. Funeral director: Wm. D. Bart & Sons

Address: Boonsboro Md

19. March 20 1945 (Date rec'd by registrar) Chas. H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 18 1945 at 6:20 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Fractured skull, hemorrhage	
Due to: and shock	
Due to: open fracture tibia & fibula (rt.)	
Other conditions	

(Incinde pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of .....

Where did injury occur? Beaverdam (City or town) Wash. (County) Md. (State)

Injured at home, farm, industry, public place (where?) Highway

Means of injury: Highway auto Injured at work? No

23. SIGNATURE: H. Robert Wells DEPUTY MEDICAL EXAM. WASH. CO., MD. M. D. or other

Address: Hagerstown, Md. Date signed: Mar. 20/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

C-24

(M)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

(3289)

Reg. Dist. No. 307

1. PLACE OF DEATH:

County Washington

City or town Gapland (If outside city or town limits, write RURAL and give nearest town) Rural

How long in above place of death? Life.

Hospital, institution, or street address where death occurred: Gapland Md.

How long in hospital or institution? at Home

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Washington

City or town Gapland (If outside city or town limits, write RURAL and give nearest town) Rural

Street No. Gapland Md. (If rural, give LOCATION)

2.(a) If veteran, name war None.

3. (a) FULL NAME George W. Kaetzel

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Ella Almira Kaetzel 6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov. 14 - 1855

8. AGE: Years	Months	Days	If less than one day
89	4	17	..... hrs. ..... min.

9. Birthplace Brownsville Wash. Co. Md. (Town, county, and state)

10. Usual occupation Retired Farmer

11. Industry or business

FATHER 12. Name Christian Kaetzel

13. Birthplace Germany

MOTHER 14. Maiden name Catherine Bowers

15. Birthplace Leitersburg Wash. Co. Md.

16. Informant Frank C. Kaetzel

Address Gapland Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 3 1945 (month) (day) (year)

Cemetery or crematory Church of the Brethren Cem.

Location Brownsville Md.

19. Funeral director Wm. D. Bard & Son.

Address Boonsboro Md.

19. Apr 2 1945 (Date rec'd by registrar) Cornelius H. Beatle, Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 31 1945 at 11 P M

21. I CERTIFY that death occurred on the date above stated: Dec I attended deceased from Dec 1 1944 to March 31 1945

and that I last saw h.. alive on March 20 1945

Immediate cause of death Cerebral Hemorrhage DURATION 3 mo.

Due to .....

Due to .....

Other conditions .....

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE William Shumaker M. D. or other

Address April 2 1945 Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 (T)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-d

03282

CERTIFICATE OF DEATH

Reg. Diat. No. 302

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 11 yrs
Hospital, institution, or street address where death occurred: 110 W. North St
How long in hospital or institution? at Home

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 110 W. Bethel St North
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: George William King

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col	Married

6.(b) Name of husband or wife: Mrs. Agnes King
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years: 73 (1872) | Months: | Days: | If less than one day: ..... hrs. ..... min.

9. Birthplace: Shanadoah Va.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER
12. Name: William King
13. Birthplace: Unknown

MOTHER
14. Maiden name: Agness Dorsey
15. Birthplace: Winchester, Va.

16. Informant: Mrs Agnes King
Address: 110 W. North St

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar 16. 45 (month) (day) (year)
Cemetery or crematory: Rosehill Cemetery
Location: Hagerstown

18. Funeral director: William H. Downey
Address: 291 Frederick St

19. March 16 1945 (Date rec'd by registrar) Chas H. Byers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar 13 1945, at 8:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1941 to Mar. 13 1945 and that I last saw him alive on Mar. 7 1945

Immediate cause of death	DURATION
Chr. Myocarditis	8 yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Robert P. Conrad, M.D. M. D. or other
Address: Hagerstown, Md. Date signed: 3-15-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1415)

03283

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 years
Hospital, institution, or street address where death occurred:
439 Mechanic Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 439 Mechanic Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Eleanor Florence Kline

3.(b) Social Security Number: 215-20-8960

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: William S. Kline
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 30, 1911

8. AGE: Years	Months	Days	If less than one day
33	2	15	hrs. min.

9. Birthplace: Big Spring, Wash. Co., Md. (Town, county, and state)
10. Usual occupation: Employee of Fairchild
11. Industry or business: Aircraft Corp.

FATHER
12. Name: Samuel Gruber
13. Birthplace: Wash. Co., Md.

MOTHER
14. Maiden name: Annie Shupp
15. Birthplace: Wash. Co., Md.

16. Informant: William S. Kline
Address: 439 Mechanic Street-Hagerstown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar. 19 45 (month) (day) (year)
Cemetery or crematory: Rose Hill Cemetery
Location: Hagerstown, Md.

18. Funeral director: Fred W. Kraiss
Address: Hagerstown, Md.

19. Mar. 18 1945 (Date rec'd by registrar) Chas. H. Boyer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 15, 1945 1:40 P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death: Gun shot wound through skull — DURATION

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results: no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Suicide Date of injury: 3/15/45
Where did injury occur? Hagerstown (City or town) Wash. (County) Md. (State)
Injured at home, farm, industry, public place (where?): Home
Means of injury: shot self Injured at work? No

23. SIGNATURE: R. Rohrer Wells DEPUTY MEDICAL EXAM. WASH. CO., MD.
M. D.
Address: Hagerstown, Md. Date signed: 3/16/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

03284

Reg. Dist. No. 302

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 years
Hospital, Institution, or street address where death occurred:
61 E. Franklin Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
WITHIN CORPORATE LIMITS
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 61 E. Franklin St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Ethel G. Knode

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feby. 4, 1919

8. AGE: Years	Months	Days	If less than one day
26	1	22	..... hrs. ..... min.

9. Birthplace: Waynesboro- Franklin Co., Pa.
(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER
12. Name: Alfred L. Knode
13. Birthplace: --------- Penn.

MOTHER
14. Maiden name: Clara Potter
15. Birthplace: Hagerstown, Md.

18. Informant: Mrs. Clara Knode
Address: 61 E. Franklin St.- Hagerstown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar. 28-45 (month) (day) (year)
Cemetery or crematory: Rose Hill Cemetery
Location: Hagerstown, Md.

18. Funeral director: Fred W. Kraiss
Address: Hagerstown, Md.

19. Mar. 28. 1945 (Date rec'd by registrar) Chas. H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 26, 1945 16:00 o'clock P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from March 23, 1945, to Mar. 26, 1945
and that I last saw h. alive on March 23, 1945

Immediate cause of death	DURATION
Chronic myocarditis	years
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: No operation Date of op.

Autopsy results: No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: R. A. Bell M. D.
Address: Hagerstown, Md. Date signed: 3/27/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03285

Reg. Diat. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 years

Hospital, institution, or street address where death occurred:

832 Mulberry Avenue

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 832 Mulberry Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Ida Lehman

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Uluses Grant Lehman

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept. 28, 1870

8. AGE: Years	Months	Days	If less than one day
74	5	26	..... hrs. ..... min.

9. Birthplace: Martinsburg- Blair Co., Pa. (Town, county, and state)

10. Usual occupation: Home Duties

11. Industry or business

FATHER

12. Name: John Law

13. Birthplace: Blair Co., Pa.

MOTHER

14. Maiden name: Sarah Mentzer

15. Birthplace: ------ Chio

16. Informant: Mrs. Lucille Yeager

Address: 832 Mulberry Ave.- Hagerstown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 29-45 (month) (day) (year)

Cemetery or crematory: Spring Hope Cemetery

Location: Martinsburg, Pa.

18. Funeral director: Fred W. Kraiss

Address: Hagerstown, Maryland.

19. Mar 28. 1945 (Date rec'd by registrar) Chas H Bowers, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 26, 1945 19 6:15 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 16, 1945, to Mar. 26, 1945 and that I last saw her alive on March 26, 1945

Immediate cause of death	DURATION
Carcinoma of Liver	2 years
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: No operation Date of op.

Autopsy results: No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: R A Bell M. D. or other

Address: Hagerstown Md. Date signed 3/27/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03286

Reg. Dist. No. 302

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Washington

City or town Rural near State Line
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Hagerstown Md. R.D.4

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Washington

City or town Rural near State Line Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. Hagerstown R.D 4 Md.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Sarah Lehman

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife David B. Lehman

6(c) If alive, give age 75 years

7. Birth date of deceased (mo., day, yr.) Mar. 18 - 1872

8. AGE:

Years	Months	Days	If less than one day
73	0	6	hrs. min.

9. Birthplace Franklin Co. Pa.
(Town, county, and state)

10. Usual occupation Usual wife

11. Industry or business

FATHER
12. Name Henry B. Hagl
13. Birthplace Franklin Co. Pa.

MOTHER
14. Maiden name Susana Lesher
15. Birthplace Franklin Co Pa

16. Informant J. Irvin Lehman
Address Chambersburg R.6 Pa.

17. Burial Date thereof Mar. 27-45
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mennonite Church

Location Near Marion Pa

18. Funeral director Mrs David Martin

Address Greencastle, Pa

19. Mar. 26, 1945 Chas H Bowers
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-24-45 19 , at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2-1-45 19 , to 3-4-45 19 ,

and that I last saw alive on 3-16-45 19

Immediate cause of death	DURATION
Ch. Myocarditis	2 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur?
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE [signature] M. D. or other

Address Hagerstown Md Date signed 3/4/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (17)

CERTIFICATE OF DEATH

03287

Reg. Dist. No. 301

1. PLACE OF DEATH:
County Washington
City or town Williamsport, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 72 yrs
Hospital, institution, or street address where death occurred:
33 W. Salisbury St. Williamsport
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Washington
City or town Williamsport, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 33 W. Salisbury St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Adulphus Henry Malone

3.(b) Social Security Number 215097324

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Daisy Lancaster Malone deceased 6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct. 10 1872

8. AGE: Years	Months	Days	If less than one day
72	5	3	..... hrs. ..... min.

9. Birthplace Williamsport, Md. (Town, county, and state)
10. Usual occupation Dope Mixer
11. Industry or business Williamsport Tannery
FATHER 12. Name John Mitchael Malone
13. Birthplace Maryland
MOTHER 14. Maiden name Sarah
15. Birthplace Maryland
16. Informant Sarah Mentzer (daughter)
Address 33 W. Salisbury St. Williamsport
17. Burial (Burial, cremation, or removal. Which?) Date thereof March 16 1945 (month) (day) (year)
Cemetery or crematory Riverview Cemetery
Location Williamsport, Md.
18. Funeral director Edith V Leaf
Address #7 Church St. Williamsport, Md.
19. 3/16 1945 (Date rec'd by registrar) Mrs E Lee McElroy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 13 1945, at 6 40 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1 1945, to March 13 1945 and that I last saw h... alive on March 12 1945

Immediate cause of death	DURATION
Gangrene of left foot	2 weeks
Due to Arteriosclerosis	2 weeks
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE [signature] M. D. or other
Address Williamsport Date signed 3/14/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

03288

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

Reg. Dist. No. 305

Dr. Viola Miller

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: Washington
City or town: Beaver Creek Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life.
Hospital, institution, or street address where death occurred: Hagerstown Md. R. 1
How long in hospital or institution? at Home

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Beaver Creek. Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No. Hagerstown Md. R. 1.
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: E. Irene Martin

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife: Single.
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): No Record

8. AGE: Years: — Months: — Days: — If less than one day: ..... hrs. ..... min.

9. Birthplace: Beaver Creek Wash. Co. Md.
(Town, county, and state)

10. Usual occupation: None

11. Industry or business: —

FATHER
12. Name: Albert B. Martin
13. Birthplace: Wash. Co. Md.

MOTHER
14. Maiden name: Ann M. Troupe
15. Birthplace: Wash. Co. Md.

16. Informant: Miss Mary E. Martin
Address: Hagerstown Md. R. 1

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 12 1945 (month) (day) (year)
Cemetery or crematory: Funkstown Cemetary
Location: Funkstown Md.

18. Funeral director: W. H. J. Bart & Sons
Address: Boonsboro Md.

19. March 12 1945 (Date rec'd by registrar) John H. Bart Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3/10. 1945 at 1:30a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 – 1945, to 3/10 1945
and that I last saw her alive on 3/9 – 1945

Immediate cause of death	DURATION
Coronary Thrombosis.	10 Hours?
arterio. Sclerosis.	5–10 Years
Due to: —	
Due to: ✓	
Other conditions: ✓	

(Include pregnancy within 3 months of death)

Major findings of operations: ✓ Date of op. .....

Autopsy results: ✓

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Viola D. Miller M. D. or other
Address: Hagerstown, Md. Date signed: 3/10 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94

03289

CERTIFICATE OF DEATH

Reg. Dist. No. 302

P.G. Bell Hosp Williamsport

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Washington
City or town Hagerstown Md.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Washington
City or town Hagerstown Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Martha K. Martin

3. (b) Social Security Number None

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: John M. Martin
6(c) If alive, give age: 73 years
7. Birth date of deceased (mo., day, yr.): Jan. 29 1877
8. AGE: Years: 68 Months: Days: If less than one day: hrs. min.
9. Birthplace: Franklin Co. Pa (Town, county, and state)
10. Usual occupation: House wife
11. Industry or business
FATHER 12. Name: Peter L. Eshleman
13. Birthplace: State Line Pa
MOTHER 14. Maiden name: Susan Royer
15. Birthplace: Franklin Co Pa
16. Informant: J. Luston Martin
Address: Jonathan Road. Hagerstown Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/28/45 (month) (day) (year)
Cemetery or crematory: Cedar Grove Church Yard
Location: Franklin Co. Pa
18. Funeral director: Mrs. David Martin
Address
19. Mar. 26 1945 (Date rec'd by registrar) Hart H Beevers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 26. 1945, 3:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 20. 1945, to March 26. 1945, and that I last saw h[illegible] alive on March 25. 1945

	DURATION
Immediate cause of death: Coronary occlusion	About 30 mins.
Due to	
Due to	
Other conditions: Bronchopneumonia	2 days

(Include pregnancy within 3 months of death)

Major findings:
Dt operations: No operation
Dt autopsy: No autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE R A Bell M. D. or other
Address Hagerstown Md. Date signed 3/26/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46 MD

03290

CERTIFICATE OF DEATH

Reg. Dist. No. 305

1. PLACE OF DEATH:

County: Washington

City or town: Beaver Creek "Rural"
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life.

Hospital, Institution, or street address where death occurred:
Hagerstown Md. R. 1

How long in hospital or institution? at Home.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Beaver Creek "Rural"
(If outside city or town limits, write RURAL and give nearest town)

Street No. Hagerstown Md. R. 1
(If rural, give LOCATION)

2.(a) If veteran, name war: None

3. (a) FULL NAME: Edna Brinham McCauley

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Divorced

6.(b) Name of husband or wife: Divorced

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): August - 1 - 1897

8. AGE:

Years	Months	Days	If less than one day
47	7	29	..... hrs. ..... min.

9. Birthplace: Beaver Creek Wash. Co. Md.
(Town, county, and state)

10. Usual occupation: Home Keeper

11. Industry or business: Own Home.

FATHER
12. Name: David C. Smith.
13. Birthplace: Near Funkstown Wash. Co. Md.

MOTHER
14. Maiden name: Annie M. Brinham
15. Birthplace: Near Mapleville Wash. Co. Md.

16. Informant: Mrs. David C. Smith.
Address: Hagerstown Md. R. 1

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 3 1945 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Hagerstown Md.

18. Funeral director: Wm. J. Bard Sons

Address: Boonsboro Md.

19. April 2, 1945 (Date rec'd by registrar) John W. Bast Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 30 1945 at 11:45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 19 1945, to Mar. 30 1945 and that I last saw h[illegible] alive on March 30 1945

	DURATION
Immediate cause of death: Peritonitis Carcinomatosis	Aug 1944
Due to:	
Due to:	
Other conditions:	

(Incinde pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Sidney Hamsher M.D.
M. D. or other

Address: Funkstown Md. Date signed 4/2/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Evidence for change of age is shown on

FILM No. G 94 MAY 15 [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

Dr Ralph Young 2231 03291

Reg. Dist. No. 30 2

1. PLACE OF DEATH:
County Washington Hospital
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 45 days at intervals Resident
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 124 High St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mamie Premelia McTz

3.(b) Social Security Number 220-18-3292

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Clarence A Myerts
6.(c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) Jan 7th 1890

8. AGE: Years	Months	Days	If less than one day
55	2	14	hrs. min.

9. Birthplace Boyce Va. (Town, county, and state)
10. Usual occupation House Wife
11. Industry or business
FATHER 12. Name John W. Hillyard
13. Birthplace Page Co. Va
MOTHER 14. Maiden name Mary Ann Pomine
15. Birthplace Clarke Co Va.
16. Informant Olive B Vincent
Address 221 West Hawked St.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/24/45 (month) (day) (year)
Cemetery or crematory Rest Haven
Location Hagerstown Md.
18. Funeral director Albert M Hafner
Address Hagerstown
19. Mar. 22. 1945 (Date rec'd by registrar) Chas H Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/21/45 19.. at 8 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3/1/45 19.. to 3/21/45 19.. and that I last saw h.. alive on 19..

Immediate cause of death Coronary Occlusion — DURATION 1 Day
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE C F Young M. D. or other
Address Williamsport, Md Date signed 3/22/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (Md)

03292

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:
County Washington (Berkeley)
City or town Hagerstown, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 years
Hospital, institution, or street address where death occurred:
Williamsport Pike
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State West Virginia County Berkeley
City or town Falling Waters, Rt. #1
(If outside city or town limits, write RURAL and give nearest town)
Street No. Near Williamsport, Maryland
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3. (a) FULL NAME Frank W. Mish, lll

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) December 4, 1929

8. AGE: Years	Months	Days	If less than one day
15	3	4	..... hrs. ..... min.

9. Birthplace Hagerstown, Maryland (Town, county, and state)
10. Usual occupation Student
11. Industry or business

FATHER
12. Name Frank W. Mish, Jr.
13. Birthplace Hagerstown, Maryland

MOTHER
14. Maiden name Mary Vernon
15. Birthplace Washington, D. C.

16. Informant Frank W. Mish, Jr.
Address Falling Waters, Rt. #1

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-10-45 (month) (day) (year)
Cemetery or crematory St. Paul Cemetery
Location Western Pike
18. Funeral director C. M. Suter & Sons
Address Hagerstown, Maryland

19 March 10, 1945 (Date rec'd by registrar) Chas. H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 8 1945 at 9:37 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death ..... DURATION
fractured (closed) cervical
Due to vertebra
Fractured (closed) lumbar
Due to vertebra
Other conditions open fracture left humerus & rt femur
(Include pregnancy within 3 months of death)

Major findings of operations None
Date of op.
Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide? Accident Date of 3/8/45
Where did injury occur? North of Williamsport (City or town) Wash. (County) Md. (State)
Injured at home, farm, industry, public place (where?) Highway
Means of injury Struck by Truck Injured at work? Yes

23. SIGNATURE Robert Lowell DEPUTY MEDICAL EXAM. WASH. CO., MD. M. D.
Address Hagerstown, Md. Date signed 3/9/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-E)

03293

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:
County Washington
City or town Rural Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Washington
City or town Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No. Leitersburg Hagerstown #5
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Walter Barkdoll Newcomer

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife Alice May Martin
6.(c) If alive, give age 82 years

7. Birth date of deceased (mo., day, yr.) February 16, 1862

8. AGE: Years	Months	Days	If less than one day
83	9	15	hrs. min.

9. Birthplace Washington Co. Md.
(Town, county, and state)
10. Usual occupation Retired Farmer
11. Industry or business

FATHER
12. Name John B. Newcomer
13. Birthplace Washington Co. Md.

MOTHER
14. Maiden name Nancy Barkdoll
15. Birthplace Washington Co. Md.

16. Informant Arthur M. Newcomer
Address Hagerstown Md. #5

17. Burial - Date thereof 3/14/45
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory St. Paul Lutheran Cemetery Leitersburg
Location Leitersburg (Hagerstown Md. #5.)

18. Funeral director Walter F. Stine
Address 27 E. Church St. Waynesboro Pa.

19 March 12 1945 Chas H Bowers
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 11 1945 at 7:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to March 11 1945
and that I last saw him alive on March 11 1945

Immediate cause of death	DURATION
Acute anaemia	10 days
Due to Chr. Nephritis	1 yr.
Due to Prostatic hypertrophy	3 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Wallis H Wishard M. D. or other
Address Waynesboro Pa. Date signed 3/12/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Dr. Ditto

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

03294

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstiown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 Year
Hospital, institution, or street address where death occurred:
941 Concord St.
How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 941 Concord St.
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: Mrs. Lydia B. Patterson

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: David
6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): March 6 1869

8. AGE: Years	Months	Days	If less than one day
75	11	29	hrs. min.

9. Birthplace: Pittsburg Alleganey Co. Pa.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Own Home
FATHER 12. Name: Henry Burton
13. Birthplace: Germany
MOTHER 14. Maiden name: Elizabeth Ritter
15. Birthplace: Germany
16. Informant: Mrs. F. A. Goetz
Address: Hagerstown Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/7/45 (month) (day) (year)
Cemetery or crematory: Rest Haven Cemetery
Location: Hagerstown Md.
18. Funeral director: Andrew K. Coffman
Address: Hagerstown Md.
19. March 6 19 45 (Date rec'd by registrar) Chas H Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 5 1945 19 ..., at 4 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 1-30-45 19 ... to 3-5-45 19 ...
and that I last saw h— alive on 2-20-45 19 ...

	DURATION
Immediate cause of death	
Chr. Myocarditis	3yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results: ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE: W. Coffman M. D. or other
Address: Hagerstown Md. Date signed 3/7/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-A)

CERTIFICATE OF DEATH

03295

Reg. Diat. No. 303

1. PLACE OF DEATH:
County: Washington
City or town: Clearspring, Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 Years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Clearspring, Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Nora Peck

3. (b) Social Security Number: NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Jobe Peck
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb. 17 1877

8. AGE: Years	Months	Days	If less than one day
68	1	5	..... hrs. ..... min.

9. Birthplace: Washington Co.
(Town, county, and state)

10. Usual occupation: Home Work

11. Industry or business

FATHER
12. Name: Sammel Sufficool
13. Birthplace: Washington, Co.

MOTHER
14. Maiden name: Not Known
15. Birthplace: ;; ;;

16. Informant: Mrs. Goldie Barton
Address: Clearspring, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March. 24 1945 (month) (day) (year)

Cemetery or crematory: Blairs Valley
Location: Near Clearspring, Md.

18. Funeral director: Snyder-Rowland
Address: Clearspring, Md.

19. March 23 1945 (Date rec'd by registrar) Joseph W. Murray Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 21 1945, at 2:30A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 25 1938 to March 21 1945 and that I last saw h[illegible] alive on March 16 1945

Immediate cause of death	DURATION
Coronary occlusion, acute	2 hrs-
Due to: Hypertensive cardiovascular renal disease	?
Due to:	
Other conditions: None.	

(Include pregnancy within 3 months of death)

Major findings of operations: None.
Date of op.: None
Autopsy results: None.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Cecil Robert Colvin M. D. or other
Address: Clearspring Md. Date signed: 3/22/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03296

Reg. Dist. No. 302

1. PLACE OF DEATH:

County: Washington Co.

City or town: Hagerstown Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 yrs

Hospital, institution, or street address where death occurred: 249 N. Jonathan St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown Md

(If outside city or town limits, write RURAL and give nearest town)

Street No. 249 N. Jonathan St

(If rural, give LOCATION)

2.(a) If veteran, name war: no

3.(a) FULL NAME: Charles Preston

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col	Married

6.(b) Name of husband or wife: Laura Preston

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): ? ? 1868

8. AGE: Years: 77 | Months: | Days: | If less than one day: ..... hrs. ..... min.

9. Birthplace: Frostburg Md (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER — 12. Name: o

13. Birthplace: o

MOTHER — 14. Maiden name: o

15. Birthplace: o

16. Informant: Mrs Laura Preston

Address: 249 N. Jonathan

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar 6 45 (month) (day) (year)

Cemetery or crematory: Burial Rose Hill

Location: Hagerstown Md

18. Funeral director: William H Downey

Address: 291 Frederick St

19. March 6 1945 (Date rec'd by registrar) Chas H Byers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 2 1945 at 6 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Chr. myocarditis	2 yrs
Due to: acute ventricular fibrillation	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: no Date of op.

Autopsy results: no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: no Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: L K Rohrer & Wells M. D. or DEPUTY MEDICAL EXAM. WASH. CO., MD.

Address: Hagerstown Md Date sig. Mar. 5/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (127-a)

CERTIFICATE OF DEATH

03297

Reg. Dist. No. 3021

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 Weeks

Hospital, institution, or street address where death occurred:

Wash. Co. Hospital

How long in hospital or institution? 4 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Boonsboro

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Church St.

(If rural, give LOCATION)

2.(a) If veteran, name war: None.

3.(a) FULL NAME: Charles McCauley Ramsburg

3.(b) Social Security Number: 217-10-3038

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

8.(b) Name of husband or wife: Edna Ramsburg

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 7 - 1881

8. AGE: Years	Months	Days	If less than one day
63	10	22	..... hrs. ..... min.

9. Birthplace: Near Myersville, Fred. Co. Md.
(Town, county, and state)

10. Usual occupation: Machinist

11. Industry or business: Victor Products Co.

FATHER
12. Name: McCauley Ramsburg
13. Birthplace: Fred. Co. Md.

MOTHER
14. Maiden name: Mary Rayman
15. Birthplace: Fred. Co. Md.

16. Informant: Mrs. Edna Ramsburg
Address: Boonsboro Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 2, 1945 (month) (day) (year)

Cemetery or crematory: Boonsboro Cemetery

Location: Boonsboro Md.

18. Funeral director: Wm. J. Bartsow

Address: Boonsboro Md.

19. Mar 30. 1945 (Date rec'd by registrar) Chas. H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 29th 1945, at 5:40 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 28th 1945, to March 29th 1945

and that I last saw him alive on March 29th 1945

Immediate cause of death	DURATION
Pulmonary Embolism	25 Minutes
Due to: Empyema of Gall Bladder	29 Days
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Hubert Wade M. D.
M. D. or other

Address: Boonsboro Md. Date signed 3/30/45

Dr. Wells

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

03298

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington

City or town Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 years

Hospital, institution, or street address where death occurred:

652 North Mulberry St.

How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 652 North Mulberry st.

(If rural, give LOCATION)

2.(a) If veteran, name war None

3. (a) FULL NAME Sherry Clinton Ridenour

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Edna F.

6.(c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) February 14 1868

8. AGE: Years	Months	Days	If less than one day
77	-	26	....hrs. ....min.

9. Birthplace Smithsburg Wash. Co. Md. (Town, county, and state)

10. Usual occupation Carpenter

11. Industry or business Retired

FATHER 12. Name Levi Ridenour

13. Birthplace Smithsburg Md.

MOTHER 14. Maiden name Malinda Steffey

15. Birthplace Smithsburg Md.

16. Informant Mrs. Edna Ridenour

Address Hagerstown Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/13/45 (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Hagerstown Md.

18. Funeral director Andrew K. Coffman

Address Hagerstown Md.

19 March 13 1945 (Date rec'd by registrar) Chas. H. Boyer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 10 1945 19.... at 2.30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1943 (im) to March 10'45

and that I last saw h... alive on March 9'45 19....

Immediate cause of death	DURATION
Paralysis Agitans	5yrs
Due to Chr. myocarditis	2 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations.... Date of op....

Autopsy results no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide no Date of ....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ....

Means of injury Injured at work?

23. SIGNATURE S. Robert Wells M.D. M. D.

Address Hagerstown, Md. Date signed 3/12/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Dr. Wade

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03299

93-D

CERTIFICATE OF DEATH

Reg. Dist. No. 303

1. PLACE OF DEATH:

County: Washington

City or town: near Hagerstown Rural.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 weeks.

Hospital, institution, or street address where death occurred: Lehman Nursing Home.

How long in hospital or institution? 7 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Boonsboro
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Church St.
(If rural, give LOCATION)

2.(a) If veteran, name war: — None —

3.(a) FULL NAME: Omer Slifer Smith

3.(b) Social Security Number: None.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Emma J. Smith

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): October - 24 - 1860

8. AGE:

Years	Months	Days	If less than one day
84	4	22	..... hrs. ..... min.

9. Birthplace: Boonsboro Wash. Co. Md.
(Town, county, and state)

10. Usual occupation: Retired Cemetary Superintendant

11. Industry or business

FATHER
12. Name: William J. Smith
13. Birthplace: Boonsboro Wash. Co. Md

MOTHER
14. Maiden name: Susan Slifer
15. Birthplace: Forest Grove Wash. Co. Md.

16. Informant: J. Hubert S. Smith
Address: 154 Frederick St. Cumberland Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 19, 1945 (month) (day) (year)

Cemetery or crematory: Boonsboro Cemetary

Location: Boonsboro Md.

18. Funeral director: Chas. J. Bast & Sons

Address: Boonsboro Md

19. March 15, 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 16" 1945, at 6.45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 16" 1943 to March 16" 1945

and that I last saw h... alive on March 16" 1945

	DURATION
Immediate cause of death: Chronic Myocarditis	1 yr. 4 mos.
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: J. Hubert Smith M. D.
M. D. or other

Address: Boonsboro Md. Date signed: 3/17/45.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

03300

CERTIFICATE OF DEATH

Reg. Dist. No. 304

1. PLACE OF DEATH:

County: Washington

City or town: Hancock

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Thirty Years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hancock

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Elwood Dennis Snyder

3.(b) Social Security Number: 217-09-7511

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct. 24 1914

8. AGE:

Years	Months	Days	If less than one day
30	5	0	..... hrs. ..... min.

9. Birthplace: Washington County (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER

12. Name: Dennis Snyder

13. Birthplace: Washington Co.

MOTHER

14. Maiden name: Elizabeth Manning

15. Birthplace: Sylvan Pa.

16. Informant: Dennis Snyder

Address: Baltimore, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar. 31 1945 (month) (day) (year)

Cemetery or crematory: Stone Bridge Cemetery

Location: Near Hancock, Md.

18. Funeral director: Snyder-Rowland

Address: Hancock, Md.

19. 3/31/45 (Date rec'd by registrar) Silbain E Jenkins Registrar

MEDICAL CERTIFICATION about

20. DATE OF DEATH: March 24 19 45, at 1:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Suffocation	
Due to: by Drowning	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of: March 24/45

Where did injury occur? Hancock Washington Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): Potomac River

Means of injury: Drunk, fell in river no

DEPUTY MEDICAL EXAM. WASH. CO., MD.

23. SIGNATURE: Robert S Wells M. D.

Address: Hagerstown Md Date signed: Mar. 30/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (40a)

CERTIFICATE OF DEATH

03301

Reg. Dist. No. 305

1. PLACE OF DEATH:

County: Washington

City or town: Rural---Boonsboro, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Wash.

City or town: Rural Boonsboro, Md
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: John Henry Starliper

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb. 9, 1945

8. AGE: Years	Months	Days	If less than one day
		22	..... hrs. ..... min.

9. Birthplace: Wash. County Hospital, Hagerstown, Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace

MOTHER
14. Maiden name: Frances Starliper
15. Birthplace: Sharpsburg, Md.

16. Informant: Mrs. David Starliper
Address: Boonsboro, Md. R. F. D. #1

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 5 1945 (month) (day) (year)

Cemetery or crematory: Mt. View

Location: Sharpsburg, Md

18. Funeral director: R. I. Earnshaw

Address: Keedysville, Md.

19. March 3 19 45 (Date rec'd by registrar) John N. Bast Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 3 19 45, at 5 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Birth 19 .. to March 3 19 45
and that I last saw him alive on March 2 19 45

Immediate cause of death	DURATION
Probably Cerebral Hemorrhage	3 mos.
Due to: Birth Injury (?)	
Due to:	
Other conditions: Rt. Inguinal Hernia.	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op.

Autopsy results: Abdomen only - no pathology.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Walter D. Shively M.D. M. D. or other

Address: Sharpsburg, Md Date signed: 3/5/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (25)

CERTIFICATE OF DEATH

63302

Reg. Dist. No. 302

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 weeks
Hospital, institution, or street address where death occurred: Washington Co Hospital
How long in hospital or institution? 8 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Penna County: Franklin
City or town: Mercersburg Pa
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Mrs Helen Ray Stenger

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Melvin B. Stenger
6.(c) If alive, give age: 51 years

7. Birth date of deceased (mo., day, yr.): Aug. 25 - 1903

8. AGE: Years	Months	Days	If less than one day
41	4	6	hrs. min.

9. Birthplace: Hagerstown Md (Town, county, and state)
10. Usual occupation: House work
11. Industry or business

FATHER
12. Name: Gus Wiebel
13. Birthplace: Hagerstown Md.

MOTHER
14. Maiden name: Mattie Lashbaugh
15. Birthplace: Stanton Va.

16. Informant: Melvin B. Stenger
Address: Mercersburg Pa

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 4-45 (month) (day) (year)
Cemetery or crematory: Fair View Cemetery Mercersburg Pa
Location:

18. Funeral director: H.E. Lininger
Address: Mercersburg, Penna.

19. March 2 19 45 (Date rec'd by registrar) Chas H Bowers, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 1, 1945, at 6:55 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 9, 1929 to March 1, 1945 and that I last saw her alive on March 1, 1945

Immediate cause of death	DURATION
Chronic Ulcerative Colitis	10 yrs.
Due to: Toxemia	Jan 6 1945
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: X X X Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: W. Howard Geyer M. D. or other
Address: Hagerstown Md Date signed March 1, 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Dr. Prather

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

033[illegible]4

Reg. Dist. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 Year

Hospital, institution, or street address where death occurred:
429 Salem n Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

Street No. 429 Salem Ave
(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: Mrs. Miriam Elsie Stone

3.(b) Social Security Number: 212-24-2870

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Divorced

6.(b) Name of husband or wife: Harry

8.(c) If alive, give age: 38 years

7. Birth date of deceased (mo., day, yr.): January 8 1910

8. AGE: Years	Months	Days	If less than one day
35	2	10	...hrs. ...min.

9. Birthplace: Hagerstown ~~3~~ Wash. Co. Md.
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: Own home

FATHER
12. Name: Guy H. Hendrickson
13. Birthplace: Hays Pa.

MOTHER
14. Maiden name: Anna mae Schuchman
15. Birthplace: Chambersburg Pa.

16. Informant: Guy H. Hendrickson
Address: Hagerstown Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/21/45 (month) (day) (year)

Cemetery or crematory: Rest Haven cemetery

Location: Hagerstown Md.

18. Funeral director: Andrew K. Coffman

Address: Hagerstown Md.

19. Mar. 19 1945 Chas. H. Bowers, Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

P

20. DATE OF DEATH: March 18 1945 at 12.30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 1 1944 to Mar. 18 1945

and that I last saw h[illegible] alive on Mar 1 1945

Immediate cause of death	DURATION
Hemorrhage	
Cancer of Uterus	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op. ...

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ...Date of ...

Where did injury occur? ...(City or town) ...(County) ...(State)

Injured at home, farm, industry, public place (where?) ...

Means of injury: ...Injured at work?

23. SIGNATURE: [illegible] M. D.

Address: Hagerstown. Md Date signed 3/13/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15


RECEIVED
MAR 21 1969
BUREAU V.

Dr Ditto

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (22)

CERTIFICATE OF DEATH

03303

Reg. Dist. No. 302

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Washington
City or town: Maugansville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 Years
Hospital, institution, or street address where death occurred:
Mennonite Home
How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washongton
City or town: Maugansville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Mennonite Home
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: Miss Lilly May Stockslager

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Single

6.(b) Name of husband or wife: ----
6.(c) If alive, give age: --
7. Birth date of deceased (mo., day, yr.): November 6 1857

8. AGE: Years	Months	Days	If less than one day
87	4	3	....hrs. ....min.

9. Birthplace: Hagerstown Wash. Co. Md.
(Town, county, and state)
10. Usual occupation: Housework
11. Industry or business: --

FATHER
12. Name: George Stockslager
13. Birthplace: Hagerstown Md.

MOTHER
14. Maiden name: Caroline Stockslager
15. Birthplace: Hagerstown Md.

16. Informant: Howard Strock
Address: Hagerstown Md. R # 4

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/21/45 (month) (day) (year)
Cemetery or crematory: Funkstown Cemetery
Location: Funkstow n Md.

18. Funeral director: Andrew K. Coffman
Address: Hagerstown Md.

19. Mar 19 1945 (Date rec'd by registrar) C Scott Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 19 1945, 19..., at 5 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 15-45, to Mar 18 1945
and that I last saw h-- alive on Mar 18-45 19...

Immediate cause of death	DURATION
Ch. Myocarditis	10yrs
Due to Senility	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: .... Date of ....
Where did injury occur? .... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ....
Means of injury: .... Injured at work?

23. SIGNATURE: H A Dutt M. D. or other
Address: Hagerstown Md. Date signed 3/19/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

03305

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:
County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 45 years
Hospital, Institution, or street address where death occurred:
328 W Washington
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 328 Washington
(If rural, give LOCATION)
2.(a) If veteran, name war Spanish American

3. (a) FULL NAME Otho Eugene Taylor

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Jan 5 - 1873

8. AGE: Years	Months	Days	If less than one day
72	2	1	____ hrs. ____ min.

9. Birthplace Sharpsburg, Washington - Md (Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER
12. Name James R Taylor
13. Birthplace Near Scramble W Va

MOTHER
14. Maiden name Elenore Grove
15. Birthplace Sharpsburg, Md

16. Informant Mrs. Bessie Zine
Address Keedysville Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 9-1945 (month) (day) (year)
Cemetery or crematory Mowalon View
Location Sharpsburg Md
19. Funeral director Scott L Minnick Son
Address Hagerstown Md

19. Mar. 8 - 1945 (Date rec'd by registrar) Chas H Bowers, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 6 1945, at 3:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feby 28 1945, to Mch 6 - 1945
and that I last saw him alive on Mch 6 1945

Immediate cause of death	DURATION
Uremia -	3 days -
Due to Chr Nephritis - + Cold -	Not known 3 days
Due to	
Other conditions High blood pressure -	not known

(Include pregnancy within 3 months of death)

Major findings of operations ____ Date of op. ____

Autopsy results ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

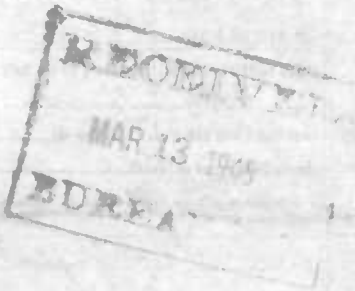
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ____ Date of ____
Where did injury occur? ____ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ____
Means of injury ____ Injured at work? ____

23. SIGNATURE Harry P Shuford M.D.
M. D. or Other
Address Hagerstown Md Date signed 3-7-45

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING


RECEIVED
MAR 13 1945
BUREAU

Dr. La Jan

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 58-a

CERTIFICATE OF DEATH

03306

Reg. Dist. No. 302

1. PLACE OF DEATH:
County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 hr.
Hospital, institution, or street address where death occurred: Wash. Co. Hospital
How long in hospital or institution? 1 hr.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Beaver Creek, Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Hagerstown Md. R.1.
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3. (a) FULL NAME: Clovis Charlotte Louise Wade.

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife: Single.
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May - 4 - 1934

8. AGE: Years	Months	Days	If less than one day
10	10	2	..... hrs. ..... min.

9. Birthplace: Smithsburg Wash. Co. Md.
(Town, county, and state)
10. Usual occupation: None
11. Industry or business: at Home.
FATHER 12. Name: Charles H. Wade.
13. Birthplace: Near Boonsboro Wash. Co. Md.
MOTHER 14. Maiden name: Mary H. Yahn
15. Birthplace: Cleversville Wash. Co. Md.
16. Informant: Charles H. Wade.
Address: Hagerstown Md. R.1
17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 9. 1945 (month) (day) (year)
Cemetery or crematory: Boonsboro Cemetary
Location: Boonsboro Md.
18. Funeral director: Wm. J. Bard & Sons
Address: Boonsboro Md.
19. Mar. 7. 1945 (Date rec'd by registrar) Chas. H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 6 1945, at 12.45 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 26 1945, to March 6 1945 and that I last saw her alive on March 6 1945

Immediate cause of death	DURATION
Acute Rheumatic Pericarditis.	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: G. W. Cellan M. D.
M. D.
Address: Boonsboro, Md. Date signed: 3/7/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

033117

Reg. Dist. No. 306

1. PLACE OF DEATH:
County: ~~Frederick~~ Wash
City or town: Smithsburg #1
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 12 Yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Frederick
City or town: Smithsburg #1
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Mollie V Wolfe Warrenfelty

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	W	Widow

6.(b) Name of husband or wife: Luther Warrenfelty
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov 25 1865

8. AGE: Years	Months	Days	If less than one day
79	3	6	hrs. min.

9. Birthplace: Smithsburg Md
(Town, county and state)
10. Usual occupation: House Work
11. Industry or business

FATHER
12. Name: William Wolfe
13. Birthplace: Smithsburg Md #1

MOTHER
14. Maiden name: Nancy A Mangans
15. Birthplace: Smithsburg Md

16. Informant: Paul W Warrenfelty
Address: Smithsburg Md #1

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3 4 1945 (month) (day) (year)
Cemetery or crematory: U B Cemetery
Location: Wolfeville Md

18. Funeral director: Walter G Grove
Address: Waynesboro Penna

19. March 3 1945 (Date rec'd by registrar) Geo W Seymour Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar 1 1945 at 7.30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 1 1945 to Mar 1 1945
and that I last saw h[illegible] alive on Mar 1 1945

Immediate cause of death	DURATION
Toxaemia	4 days
Due to Carcinoma of Sigmoid & of Ov	6 mos
Due to	
Other condition Arterio Sclerosis	10 yrs

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [illegible] M. D. or other
Address: Smithsburg Md Date signed 3/4/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (19-6)

CERTIFICATE OF DEATH

033118

Reg. Dist. No. 302

1. PLACE OF DEATH:
County: Washington Co.
City or town: Hagerstown Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20
Hospital, institution, or street address where death occurred:
238 N. Jonathon S
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DEASCED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hagerstown Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 238 N. Jonathon St.
(If rural, give LOCATION)
2.(a) If veteran, name war: no one

3. (a) FULL NAME: Irving Wesley

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.):

8. AGE: Years	Months	Days	If less than one day
55 1889	Oct	5	hrs. min.

9. Birthplace: Hagerstown Md
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER
12. Name: William Wesley
13. Birthplace: Lynchburg Va

MOTHER
14. Maiden name: Fannie Coles
15. Birthplace: Morgansville Md

16. Informant: Mrs Gertude Wesley
Address: 238 N. Jonathon St

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar 7 45 (month) (day) (year)
Cemetery or crematory: National Cemetery
Location: Sharpsburg Md.

18. Funeral director: William H. Downey
Address: 291 Frederick St

19. March 6 1945 (Date rec'd by registrar) Chas H Divers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 4 1945, at 4A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Chr. myocarditis	4 yrs
Due to: chr. glomerular nephritis	2 yrs
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: no
Date of op.
Autopsy results: no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: no Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: L Roland Wells M. D.
DEPUTY MEDICAL EXAM., WASH. CO., MD.
Address: Hagerstown, Md. Date signed: March 5/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

03309

Reg. Dist. No. 307

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14 years

Hospital, institution, or street address where death occurred: 136 East Franklin Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 136 East Franklin Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Isaac P. Wert

3.(b) Social Security Number: 214-09-5691

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Verna K. Wert

6.(c) If alive, give age: 56 years

7. Birth date of deceased (mo., day, yr.): May 5, 1886

8. AGE: Years	Months	Days	If less than one day
58	10	1	hrs. min.

9. Birthplace: Millersburg, Pa. (Town, county, and state)

10. Usual occupation: Cutter

11. Industry or business: Hagerstown Shoe & Legging

FATHER — 12. Name: William Wert

FATHER — 13. Birthplace: Millersburg, Pa.

MOTHER — 14. Maiden name: Ann Hetrick

MOTHER — 15. Birthplace: Millersburg, Pa.

16. Informant: Mrs. Isaac P. Wert

Address: Hagerstown, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-9-45 (month) (day) (year)

Cemetery or crematory: Oak Hill Cemetery

Location: Millersburg, Pa.

18. Funeral director: C. M. Suter & Sons

Address: Hagerstown, Maryland

19. Mar. 8 1945 (Date rec'd by registrar) Ehret H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 6 1945, at 4.15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3/5 1943 to 3/6 1945

and that I last saw him alive on 3/4/45 1945

Immediate cause of death	DURATION
Acute Coronary occlusion	Sudden
(Presumptive diagnosis - died in sleep)	death
Due to: Coronary artery disease	6 years
Due to:	
Other conditions: Chr. arterial hypertension	6 years

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: John N. Hornbaker M. D. M. D. or other

Address: 154 W. Washington St. Hagerstown, Md. Date signed: 3/7/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

CERTIFICATE OF DEATH

03310

Reg. Dist. No. 302

1. PLACE OF DEATH:
County: Washington County
City or town: 930 Pope Ave. Hagerstown, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yrs 3 Months 6 days
Hospital, institution, or street address where death occurred:
930 Pope Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: 930 Pope Ave. Hagerstown, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Same as Above
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Ora Lee Wingerd

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Baby

6.(b) Name of husband or wife: Baby
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 1 1942

8. AGE: Years	Months	Days	If less than one day
2	3	6	hrs. min.

9. Birthplace: Washington County Hospital Hagerstown Md. (Town, county, and state)
10. Usual occupation: Baby
11. Industry or business:

FATHER
12. Name: George Wingerd
13. Birthplace: Chambersburg Pa.

MOTHER
14. Maiden name: Vivian Spence
15. Birthplace: Sharpsburg, Md.

16. Informant: Vivian Wingerd (Mother)
Address: 930 Pope Ave. Hagerstown, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 9 1945 (month) (day) (year)
Cemetery or crematory: Rosehill Cemetery
Location: Hagerstown, Md.

18. Funeral director: Edith V Leaf
Address: #7 Church St. Williamsport, Md.

19. March 9 1945 (Date rec'd by registrar) Mar. 9. 1945 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 6, 1945, 5:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 6, 1945 19 to March 6, 1945 and that I last saw her alive on Feb. 23, 1945 19

Immediate cause of death	DURATION
Broncho-pneumonia	3 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: 148 W. Washington St. Date signed: 3/7/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (636)

CERTIFICATE OF DEATH

(3331) Reg. Dist. No. 301

1. PLACE OF DEATH:
County: Washington County
City or town: St. James Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 33 yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: St. James Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: St. James Md.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Nellie Potterfield Wittkofsky

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Frank Wittkofsky
6.(c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): Sept. 18 1882

8. AGE: Years	Months	Days	If less than one day
62	5	19	hrs. min.

9. Birthplace: W. Va.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Robert Jordon
13. Birthplace: W. Va

MOTHER
14. Maiden name: Mary Rice
15. Birthplace: W. Va.

16. Informant: Frank Wittkofsky
Address: St. James Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 14 1945 (month) (day) (year)
Cemetery or crematory: Greenlawn Cemetery
Location: Williamsport, Md.

18. Funeral director: Edith V Leaf
Address: #7 Church St. Williamsport, Md.

19. March 12 1945 (Date rec'd by registrar) Mrs E Lee McElroy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar. 8 1945 at 11 61 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar. 8 1945, to Mar. 8 1945
and that I last saw h.. alive on Mar. 8 1945

Immediate cause of death	DURATION
Coronary Occlusion.	2 Hours
Due to Endocarditis Chronic	2
Due to Toxic Nephritis	2
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: M. D. or other
Address: Williamsport Md. Date signed: 3/9/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RC Dr. Conrad

03312

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (137)

CERTIFICATE OF DEATH

Reg. Dist. No. 305

1. PLACE OF DEATH:

County: Washington

City or town: Breathedsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 Mos

Hospital, Institution, or street address where death occurred:
Maryland State Penal Farm

How long in hospital or institution? 6 Mos

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: ~~Baltimore~~

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 617 Jasper St.
(If rural, give LOCATION)

2.(a) If veteran, name war: None

3. (a) FULL NAME: George William Yorker

3. (b) Social Security Number: 218-12-3010

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife: --

6.(c) If alive, give age: -- years

7. Birth date of deceased (mo., day, yr.): July 24 1926

8. AGE: Years	Months	Days	If less than one day
18	8	6	...hrs. ...min.

9. Birthplace: Baltimore, Baltimore Co. Md.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: --

FATHER
12. Name: William Horsey
13. Birthplace: No Record

MOTHER
14. Maiden name: Myrtle Yorker
15. Birthplace: Non Record

16. Informant: Maryland State Penal Farm
Address: Breathedsville Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/2/45 (month) (day) (year)

Cemetery or crematory:

Location: Baltimore Md.

18. Funeral director: Andrew K. Coffman

Address: Hagerstown Md.

19 March 31 1945 (Date rec'd by registrar) John A. Dark Registrar

MEDICAL CERTIFICATION P

20. DATE OF DEATH: March 30 1945 19... at 6.30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 1 19 45 to Mar 30 19 45

and that I last saw h~~im~~ alive on Mar 29 19 45

Immediate cause of death: Pulmonary Tuberculosis — DURATION: 7 yrs.

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Robert P. Conrad, M.D.
M. D. or other

Address: Hagerstown, Md. Date signed: 3-31-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (74a)

03313

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington

City or town Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? One Day

Hospital, Institution, or street address where death occurred:

Washington Co. Hospital

How long in hospital or institution? One Day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Hancock, Rural # 2

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Frances Younker

3. (b) Social Security Number NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife William E. Younker

6.(c) If alive, give age 80 years

7. Birth date of deceased (mo., day, yr.) January 26 1866

8. AGE: Years	Months	Days	If less than one day
79	1	15	..... hrs. ..... min.

9. Birthplace Washington County (Town, county, and state)

10. Usual occupation House Work

11. Industry or business

FATHER 12. Name Samuel Weller

13. Birthplace Washington Co.

MOTHER 14. Maiden name Barbria Myers

15. Birthplace Washington Co.

16. Informant William E. Younker

Address Hancock, Md. R.F.D. # 2

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 14 1945 (month) (day) (year)

Cemetery or crematory Orchard Ridge Cemetery

Location Near Millstone, Md.

18. Funeral director Snyder & Rowland

Address Hancock, Md.

19. March 13 1945 (Date rec'd by registrar) Chas. H. Boerst, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 11 1945 at 9.45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 10 1945, to March 11 1945 and that I last saw her alive on March 11 1945

Immediate cause of death	DURATION
Occlusion Posterior Coronary Artery	7 days
Due to Arteriosclerosis	?
Due to Gall Stones	?
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None. Date of op. None.

Autopsy results As above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Archie Robert Colvin M. D. or other

Address Clearspring Md. Date signed 3/12/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (165)

03314

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:
County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Wash. Co. Hospital
How long in hospital or institution? 3 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Washington
City or town Hancock, Md. R D 1
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Gary Lee Younker

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 20, 1945

8. AGE:	Years	Months	Days	If less than one day
	0	1	26	hrs. min.

8. Birthplace Hancock, Md.
(Town, county, and state)
10. Usual occupation None
11. Industry or business

FATHER
12. Name Samuel E. Younker
13. Birthplace Hancock, Md.

MOTHER
14. Maiden name Dolores Shoemaker
15. Birthplace Hancock, Md.

16. Informant Harry C. Younker
Address Hancock, Md. R D 1

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 21, 1945 (month) (day) (year)
Cemetery or crematory Park Head Cemetery
Location Rural Clear Spring, Md. Route 40 W

18. Funeral director Snyder-Rowland Funeral Home
Address Hancock, Md.

19. Mar. 20. 1945 (Date rec'd by registrar) Chas. H. Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 18, 1945 19 6:53 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Gunshot wound through abdomen	
Due to Hemorrhage and shock	
Due to	
Other conditions	

(Incinde pregnancy within 3 months of death)

Major findings of operatioos
Date of op.
Aotopsy results
PHYSICIAN: Please uoderlioe the caose to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Homicide Date of 3/17/45
Where did injury occur? Hancock (City or town) Wash. (County) Md. (State)
Injured at home, farm, industry, public place (where?) Highway
Means of injury Shot with revolver Injury at work? No

23. SIGNATURE J. Robert Wells DEPUTY MEDICAL EXAM. WASH. CO., MD. M. D. or
Address Hagerstown, Md. Date signed 3/19/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03315

CERTIFICATE OF DEATH

Reg. Dist. No. 304

1. PLACE OF DEATH:
County: Washington
City or town: Hancock R D 1 Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 23 years
Hospital, Institution, or street address where death occurred: Near Cohill Station
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Rural Hancock, Md. R D 1
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Samuel Elmer Younker

3.(b) Social Security Number: 220-18-0280

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Dolores Shoemaker
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 18, 1922

8. AGE: Years 22 | Months 9 | Days 28 | If less than one day: hrs. min.

9. Birthplace: Hancock, Wash. Co., Md.
(Town, county, and state)

10. Usual occupation: B. and O. R. R. Co.

11. Industry or business: Pipefitter

FATHER
12. Name: Harry C. Younker
13. Birthplace: Wash. Co., Md.

MOTHER
14. Maiden name: Lula Moore
15. Birthplace: Berkley Springs, W. Va.

16. Informant: Harry C. Younker
Address: Hancock, Md. R D 1

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 21, 1945 (month) (day) (year)
Cemetery or crematory: Park Head Cemetery
Location: Rural Clear Spring, Md. Route 40 W

18. Funeral director: Snyder-Rowland Funeral Home
Address: Hancock, Md.

19. Mar 21 1945 (Date rec'd by registrar) Lillian E. Jenkins Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 18, 1945, 19 11:30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Gunshot wound through heart	
Hemorrhage and shock	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide? Suicide Date of injury 3/18/45
Where did injury occur? Hancock (City or town) Wash. (County) Md. (State)
Injured at home, farm, industry, public place (where?) Highway
Means of injury Shot with revolver Injured at work? No.

23. SIGNATURE: L. Rohr & Wells DEPUTY MEDICAL EXAM. WASH. CO., MD.
M. D. or Coroner
Address: Hagerstown, Md. Date signed: 3/19/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

Dr. Hornbaker 03316

CERTIFICATE OF DEATH

Reg. Diat. No. 302

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 Years

Hospital, institution, or street address where death occurred:

318 Summit Ave

How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 318 Summit Ave

(If rural, give LOCATION)

2.(a) If veteran, name war: None

3. (a) FULL NAME: Mrs. Anna Pearl Zeigler

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fenale	White	Married

6.(b) Name of husband or wife: Harvey P.

6.(c) If alive, give age: 58 years

7. Birth date of deceased (mo., day, yr.): March 17 1889

8. AGE: Years	Months	Days	If less than one day
55	11	18	....hrs. ....min.

9. Birthplace: Hagerstown Wash. Co. Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own Home

FATHER

12. Name: George M. Davis

13. Birthplace: Hagerstwon Md.

MOTHER

14. Maiden name: Anna M. Henson

15. Birthplace: Hagerstown Md.

16. Informant: Harvey Paul Zeigler

Address: Hagerstown Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/8/45 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Hagerstown Md.

18. Funeral director: Andrew K. Coffman

Address: Hagerstown Md.

19. March 7 19 45 (Date rec'd by registrar) Chas. H. Bowers, Registrar

MEDICAL CERTIFICATION

P

20. DATE OF DEATH: March 5 1945 19.... at 11.30 M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 11-18 19 44, to 3-5- 19 45

and that I last saw h.. alive on 3/5/45 19....

	DURATION
Immediate cause of death: Acute Coronary Occlusion	1 hour
Due to: Arteriosclerosis of Coronary Arteries (Angina pectoris of 1 weeks duration prior to death)	Unknown
Due to:	
Other conditions: None	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op. ....

Autopsy results: Not done -

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.... Date of ....

Where did injury occur? .... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ....

Means of injury: .... Injured at work?

23. SIGNATURE: Lee N. Hornbaker M. D.

Address: 154 W. Washington St. Hagerstown, Md. M. D. number ....

Date signed: 3/6/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15